Attachment B

Description of Expansion Population

REPORT BY THE MAINE DEPARTMENT OF HUMAN SERVICES TO THE 119TH MAINE LEGISLATURE RELATED TO METHODS TO INCREASE ACCESS TO HEALTH *CARE* FOR LOW-INCOME MAINE PEOPLE

PREPARED BY
THE INSTITUTE FOR HEALTH POLICY
MUSKIE SCHOOL OF PUBLIC SERVICE

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EXECUTIVE SUMMARY

The 119th Maine Legislature directed the Department of Human Services to study methods to increase access to health care for low-income Maine citizens who are not now eligible for the Medicaid program. This population consists primarily of low-income adults between the ages of 21 and 65 who are not parents or guardians of children.

This report responds to the Legislature's request by studying the experience of other states that have expanded publicly funded coverage to similar populations and by using their experience to estimate likely program enrollment and costs for Maine. The principal findings of this study are the following:

- Census Bureau data indicate there are approximately 32,600 non-parenting adults in Maine with incomes below 125% of the federal poverty level (FPL). The number of such adults with incomes below 150% FPL is 42,700.

- If national rates of uninsurance for adults in these income categories hold true in Maine, the number of uninsured adults with incomes below 125% FPL in Maine is approximately 18,960, and below 150% FPL the number is approximately 23,200.

- Although Maine has health care resources for medically indigent persons, these resources are inadequate to meet the volume and scope of care needs of the uninsured population. Survey data from Maine and the nation indicate that low-income uninsured persons are in poorer health than the insured population, but use fewer health care resources. Maine providers absorbed approximately $164 million in bad debt and charity care in 1999 for services provided to uninsured persons. Much of the cost of uncompensated care is passed on through increased charges to private payers.

- The cost experience of other states in covering similar populations has varied widely based on scope of benefits and other factors. Using the experience of these states to estimate high and low parameters of expected costs, we have estimated total annual costs ranging from approximately $9 million to $36 million for a program with an eligibility threshold of 125% FPL. The estimates for a program with an eligibility threshold of 150% FPL range from $11 million to $44 million.

- Some states fund their programs for non-parenting adults with state-only dollars generated through new taxes, tobacco settlement dollars, or state general revenues. At least 10 states have obtained 1115 waivers from HCFA allowing them to expand Medicaid coverage to this population. An 1115 waiver can only be obtained if a state can demonstrate that the program will be cost neutral to the federal government. However, with an 1115 waiver, a state receives federal matching dollars for program costs. Costs are thus reduced for the state but the state must still fund the state match of program costs. With an 1115 waiver for this population, Maine would need annual state revenues between $3 million and $12 million for the more limited eligibility program and $4 million to $15 million for the program with eligibility up to 150% FPL.

I. Introduction

This report responds to the request of the 119th Maine Legislature, "Directing the Department of Human Services to study methods to increase access to health care for low-income Maine people" (Public Law 99, Chapter 29). This resolve required that the Department study methods by which funds, including federal matching funds, may be obtained to provide medical assistance to adult residents of the State with incomes below 125% of the Federal Poverty Level (FPL) who do not now have access to care through the Medicaid Program.

In particular, the Department was instructed to provide a report to the Joint Standing Committee on Health and Human Services including the following information:

- An estimate of the number of individuals with incomes under 125% of the Federal Poverty Level who are ineligible for the Medicaid Program;
- An analysis of the financial impact and the health risks, including the long-term health costs, resulting fiom this population being uninsured;
- A survey of other states which are providing coverage to this group, and how that coverage is financed; and
- The cost of providing coverage to this group under the Medicaid Program.

Following passage of the Resolve, the House Chair of the Joint Standing Committee on Health and Human Services, requested that the Department also address the cost of covering uninsured adults below 150% of the Federal Poverty Level as part of this report.

Background

Historically, Medicaid eligibility has been tied to eligibility for cash assistance, the AFDC and SSI programs, and provided coverage only to families with children, the elderly, and people with disabilities who met income eligibility guidelines. Over the past twenty years, Congress has expanded eligibility, both through mandates and through new optional coverage categories to new groups who did not previously qualify for Medicaid benefits. Initially these expansions focused on pregnant women and children and the elderly and both uncoupled Medicaid eligibility fkom receipt of cash assistance and raised the income thresholds states could consider for eligibility determination.

Congress has also given the Health Care Financing Administration (HCFA, the federal agency that oversees the Medicare and Medicaid programs) the power to grant Research and Demonstration Waivers (1115 Waivers) to states to experiment with approaches to providing services through the Medicaid program. 1115 Waivers have been used by a number of states to expand eligibility to groups not eligible for traditional Medicaid.

Finally, the passage, in 1997 of the SCHIP program (State Children's Health Insurance Program) increased state flexibility further. SCHIP expanded income eligibility upwards for children, especially school-aged children and young, dependent adults (through age 18). For their SCHIP plans, States could implement non-traditional benefit arrangements,

for example, matching program benefits to their state employee health benefit plan instead of traditional Medicaid covered services. States could also consider requiring modest premium payments and contract for health services with managed care networks.

Because of the alternative avenues for covering children under traditional Medicaid and the SCHIP program, states have been using 1115 waivers to turn their attention to low-income, working age adults. At both the federal and state levels, policy makers initially prioritized coverage for low-income parents of children eligible for Medicaid or SCHIP. Now, using federal waiver provisions (discussed in greater detail below), some states have expanded coverage to the remaining low income uninsured population -- primarily adults without minor children who are neither elderly nor disabled.

Maine's Medical Assistance Promams -- Current Coverage

Current coverage categories and income eligibility thresholds in Maine reflect the changes in federal authorization over the past 20 years. In addition to expanding eligibility within traditional categories, Maine implemented a SCHIP program in 1998 through both a Medicaid expansion and the development of a separate program for children in higher income households that requires sliding scale premium contributions. In Maine, the stand-alone SCHIP program is named Cub Care. The current coverage categories and income thresholds for Maine's Medical Assistance Programs are as follows:

Eligibility Group	Medicaid	Cub Care
Infants < 12 months	185% of FPL*	186%-200% of FPL
Children age 1 through 18	150% of FPL	151%-200% of FPL
Young adults age 19 & 20	150% of FPL	
Parents of Medicaid children	150% of FPL	
Pregnant women	200% of FPL	
Persons age 65+	100% of FPL	
Persons with disabilities	A. Unearned must be <100% of FPL B. Unearned and earned must be < 250% of FPL	
Persons in long term care	Varies depending on setting	

* Federal Poverty Level

II. Estimates of Numbers of Maine **Low-income Adults** Without Medical **Assistance** Eligibility

An analysis of the number of Maine adults who might be eligible for (and participate in) an expansion of Medicaid to currently ineligible, low-income adults, requires a series of estimates -- none of them exact.

Currently in Maine, Medicaid coverage is available for young adults age 19 and 20 up to 150% of the federal poverty level (FPL) and almost all persons age 65 and older are eligible for coverage through the Medicare program. In addition, Medicaid coverage has been extended to the parents of eligible children. Therefore, estimates are provided for Maine non-parenting adults, ages 21 through 64 with incomes below 150% of FPL.

According to national census data, the numbers of adults Without dependent children in Maine without coverage through public insurance programs are as follows (numbers based on 1990 Census data. See ***Appendix A*** for greater detail):

	Number	Cumulative
In households below 100% of the federal poverty level:	23,511	23,511
In households between 100 and 124% FPL:	8,641	32,152
In households between 125 and 149% FPL:	9,956	42,108

Some portion of these individuals have private health insurance. National Census data from 1999 indicate that, nationally, among persons living in poverty, the uninsurance rate for those without public coverage is 63%; among adults with incomes between 100% and 125% FPL, the rate is 48%; and for the group between 125% and 150% FPL, the equivalent rate is 43%. If these national rates are applied to the Maine population, an estimate of adults who would be eligible for a program limited to uninsured childless adults emerges as follows':

Household Income	Number	Proportion Uninsured	Total Uninsured	Cumulative Total
less than 100% FPL	23,511	63%	14,812	14,812
100% - 124% FPL	8,641	48%	4,148	18,960
125% - 149% FPL	9,956	43%	4,281	23,241

Thus, for a program targeted to persons under 125% FPL, the total eligible population is estimated at 18,960, and for a program targeted to persons under 150% FPL, the target group is estimated to be 23,241.

III. Health Risks and Impact of Being Uninsured

Resources Available to Low Income Uninsured Individuals In Maine

Although Maine has health care resources for medically indigent persons, these resources are inadequate to meet the volume and scope of care needs of the uninsured population. Maine has no city or county public hospitals and the state Public Health Department does not support an infrastructure of direct service clinics or providers. Nevertheless, a range of medical care services is available to medically indigent individuals at various locations throughout the state.

Ambulatory Care

Maine has 7 federally qualified, community and migrant health care center (FQHC) sponsors that provide ambulatory care services at 26 locations. These centers receive federal support and are required to offer free and sliding scale services to low-income, uninsured individuals. There are, additionally, three FQHC "look-alike" health centers in Maine. These centers do not receive federal grant funding but do receive cost-based reimbursement like the FQHCs, and are a guaranteed health care access point for uninsured persons. While all these centers serve disproportionately low-income and uninsured populations (see *Appendix B*) their limited sites and capacity enable them to meet *only* a portion of the need for health care among vulnerable populations in the state. Medically underserved areas in Maine also are eligible as practice sites for practitioners from the National Health Service Corps.[2] Maine currently has 49 health care providers from the National Health Service Corps. These providers are drawn fkom the following professions: 26 physicians; 9 physician assistants; 5 nurse practitioners; 5 mental health providers; and 4 dentists? All of these federally subsidized resources offer primary care services and do not broaden access to specialty care for medically indigent uninsured persons.

Additional ambulatory care is provided to medically indigent persons in a number of locations *through* free clinics and hospital clinics and outpatient departments. A free clinic funded through local health department dollars operates in Portland. Free clinics operating primarily on volunteered professional time from local providers see patients in Biddeford, Rockland, and Brunswick. Maine Medical Center, Eastern Maine Medical Center and MaineGeneral all have family residency programs and have outpatient clinics associated with the residency programs. These clinics serve as a resource for uninsured and indigent patients.

Finally, there are in development or operational, a number of provider-sponsored initiatives designed to broaden access to a full range of coordinated medical care services for low-income, uninsured individuals ineligible for coverage through Medicaid or any other program. These programs are based on voluntary participation by a broad range of providers including primary care and specialty care physicians and hospitals, all of whom agree to provide clinical services without charge to enrolled individuals. The programs also include case managers who help enrolled individuals develop a care pian, direct

them to appropriate resources within the provider network, and help enrolled individuals become active participants in maintaining their health. MaineHealth, for example, under the auspices of the Robert Wood Johnson Foundation, Communities in Charge Initiative, is developing a demonstration project, *Carepartners,* in three counties -- Cumberland, Lincoln, and Kennebec. The program will be available to uninsured individuals with incomes below 150% of the federal poverty level. In addition to its participation as a provider in this program, Maine Medical Center has provided *funding* for initial program infrastructure development and to support the cost of prescription medications for enrolled participants. In Kennebec County, MaineGeneral's MATCH program, a charity care program of much the same model, is participating in the Carepartners' demonstration and will serve as a site of care for enrollees. Similar models are under development or operational at York Hospital and at Franklin Hospital.

These private initiatives, while presenting an exciting innovation in that they are attempting to coordinate comprehensive health care services and assure access to specialty care, when needed, are necessarily limited in scope. Funded solely through private resources and donated services, these programs must maintain very stringent eligibility criteria and cap enrollment a levels substantially below the level of need.

Hospital Care

Maine law requires hospitals to provide urgent medical care without charge to patients with incomes below 100% of the federal poverty level upon demand. Most hospitals in Maine provide charity care and uncompensated care at levels above this legislatively mandated level. In 1999, Maine hospitals provided over $105 million in unpaid hospital services to uninsured persons (see *Appendix C* for tabulation of out-of-pocket expenditures and charity care expenditures generated by uninsured persons in Maine, in 1999).[4]

Impact of Lack of Coverage on Health Status

Despite the availability of resources for medically indigent persons in Maine such as the federally funded health centers, -- and the willingness of Maine providers to serve as an informal safety net for uninsured persons needing medical care -- there is ample evidence of adverse health consequences associated with lack of health coverage.

A recent national study reports that uninsured individuals with the five most common chronic health problems receive substantially less care for these conditions than their insured counterparts. Uninsured persons with heart disease, hypertension, high cholesterol, arthritis, and chronic back pain, receive half the number of lab tests that their insured counterparts receive, are much more likely to go without medicines appropriate to their conditions, obtain far fewer screenings for high blood pressure or cholesterol, and make 19 to 28 percent fewer visits to physicians.[5]

In Maine, one recent survey found that 21 percent of poor individuals, currently or recently without insurance coverage, reported their health status as fair or poor. Among

uninsured individuals with incomes between 100 and 150 percent of the federal poverty level, the proportion in poor or fair health was 12 percent. And for those with incomes between 150 and 200 percent FPL the proportion was 10 percent. Approximately one in four of the uninsured in this Maine study report that they had needed medical services they didn't receive during the past 12 month period. Among the most frequently reported foregone services were health screenings, vision care, medications, and dental care. Among the uninsured who reported needing prescription medication over the prior year, 60 percent reported foregoing, delaying, or cutting dosage on medications, due to cost.[6]

Other evidence of unmet need in Maine associated with medical indigence comes fkom survey information on Maine citizens fiom the Bureau of Health's Behavioral Risk Factor Surveillance System.' This survey indicates, for example that the proportion of adults in Maine who did not visit a doctor because of cost within the prior 12 months was close to 10 percent in 1998. The rate of foregone doctor visits among adults has been higher in Maine than in the nation as a whole, since 1996. Among women between the ages of 36 and 50, over 8 percent in Maine report not having had a Pap Smear within the past five years, and among women over age 50, 5 percent report not having had a breast exam in five years.'

IV. Financial Impact of the Uninsured Population on Health Care Costs

As indicated in the section above, much of the care received by low-income uninsured persons in Maine is provided as uncompensated care by physicians, hospitals, and other providers. Much of this burden on providers is passed along to other payers in cost mark-ups. In addition, the survey data discussed above supports the contention that the uninsured delay health screening exams, sometimes forego taking important medications, and present at the hospital or physician office with preventable acute conditions requiring intensive and expensive interventions.

It is difficult to estimate, precisely, the cost impact of these combined forces. The Maine Blue Ribbon Commission on Health Care reported total personal health care expenditures of the uninsured in 1999 to be $271 million, about 5 percent of total personal health care expenditures for the state as a whole. Of this amount, uninsured persons were estimated to have paid about $107 million, with $164 million absorbed as bad debt or charity care by providers and passed on to other payers (see Appendix C).

By far, the largest proportion of uncompensated care provided to uninsured individuals in Maine is absorbed by Maine hospitals. As indicated earlier, Maine hospitals experienced approximately $105 million in bad debt and charity care in 1999. This is approximately 91 percent of the total hospital expenditures attributed to the uninsured. By contrast, the uninsured paid, out of pocket, approximately $38.5 million for physician services in 1999 -- approximately half of their incurred expenses. The uninsured also spent close to $35 million, or an average of $210 per person, on prescription drugs, none of which was subsidized or written off.

According to the Blue Ribbon Commission, the total uncompensated care burden associated with the personal health care expenditures of the uninsured, increased the spending of private insurers in Maine approximately $100 million dollars, from $1.9 billion, to $2.0 billion?

V. Survey of State Programs for Coverage of Low-income, Non-Parenting Adults

A survey of the states indicates that at least 10 states have coverage expansion programs that are targeted to or include uninsured adults without children. These states include: Delaware, Hawaii, Massachusetts, Minnesota, Missouri, New Jersey, Oregon, Tennessee, Vermont and Washington. Two additional programs, one in New York and one in Arizona, have recently been authorized but lack operational experience. *Appendix D* summarizes some of the basic characteristics of these programs.

Profiled below are four programs, selected because, 1) they have been operational for a long enough period to achieve substantial enrollment and generate cost experience; and 2) their eligibility criteria approximate the population specified by the Maine legislature or they can provide cost experience broken out for this population.

Diamond State Health Plan (Delaware)@

The Diamond State Health Plan (DSHP) was created through an 1115 demonstration waiver, approved by HCFA in 1995. Using savings achieved by enrolling the bulk of Delaware's Medicaid population into managed care, the DSHP was able to extend Medicaid coverage to uninsured adults up to 100% of the federal poverty level (FPL). This includes individuals and couples with or without children.

Eligibility: Adults 19 to 64 who are not eligible for any other Delaware Medicaid category. Must be uninsured to enroll; does not permit wrap-around coverage. To reduce the risk of "crowd out," Delaware requires that enrollees have been uninsured for six months, however this requirement can be waived for applicants who have lost coverage involuntarily.

Benefits: Primary, acute, mental health and substance abuse services. Limitations include 30-day maximum on inpatient MH/SA care and 20-session maximum on outpatient MH/SA care. Dental care, chiropractic services, and non-emergency transportation are not covered.

Program Size: Current enrollment (April 2001) is approximately 19,000 or 19 percent of the entire Delaware Medicaid population.

Program Administration: All enrollees must enroll in a managed care plan, except that individuals with HIV/AIDS can opt out and receive services through an AIDS waiver. Currently two private managed care organizations provide the bulk of Medicaid services

under a fully capitated payment arrangement. All pharmacy benefits are managed by the state of Delaware itself, and are paid on a fee-for-service basis.

Premiums: No premiums or other cost-sharing mechanisms.

Recertification: Every 6 months.

Cost experience: Current cost for the 19-64 expanded population (including individuals and couples with children) is approximately $250 per member per month. According to the Medicaid Director, the expanded population is composed primarily of adults without children.

Minnesota[11]

Minnesota has two different enrollment options for low-income, childless adults. **MinnesotaCare** expanded coverage to low-income persons aged 21 and over, who are non-parents in 1994. As of 1997, the income eligibility for this category had been increased to 175% of the federal poverty level. This group is not encompassed within the state's 1115 waiver and the state does not receive federal cost sharing for their coverage. In addition, Minnesota's **General Assistance Medical Care program (GAMC)** provides medical care for low-income Minnesotans who don't qualify for Medicaid or other programs, primarily single, low-income adults between the ages of 21 and 64. This program, too is funded entirely with state dollars.

Eligibility: Adults over age 21, regardless of citizenship, who have no children and whose income is at or below 175 percent of the federal poverty level. Persons must have lived in Minnesota at least six months and **must** have been without health insurance for at least four months. Individuals who have access to employer based health insurance where the employer pays **50%** or more of the premium are ineligible. Persons whose employer dropped coverage within the past 18 months are ineligible.

GAMC, but not MinnesotaCare coverage, may be used to help pay premiums for other health insurance.

Benefits: MinnesotaCare and GAMC provide very comprehensive benefits, although with some slight differences. The differences are high-lighted below.

MinnesotaCare covers:

- Comprehensive ambulatory care including all physician and health clinic visits.
- Preventive dental care (teeth cleaning, X-rays, oral exams)
- Eye checkups and prescription glasses
- Home care including nurse visits and home health aides
- Hospicecare
- Mental health services
- Prescription drugs with a $3 copay

- Hospital coverage is limited to a maximum of $10,000 per year and there is a 10% copayment up to $1,000 per adult.

MinnesotaCare excludes:

- Non-preventive dental care
- Nursing home or intermediate care facilities
- Private duty nursing
- Personal care attendant services
- Non-emergency medical transportation

GAMC coverage differs in that it includes:

- Full hospital care without copayments or limits
- Prescription drugs without copayments
- Full dental services
- Orthodontic care
- Family planning
- Hearing Aids
- Transportation for medical appointments

GAMC exclusions include:

- Inpatient mental health care
- Home health services
- Physical, occupational and speech therapy, and audiology
- Pregnancy and related services
- Nursing home care
- Hospice care
- Payment for missed appointments
- Unauthorized services when a physician order was required

Program Size: As of January 2001, 22,210 adults Without children were enrolled in MinnesotaCare, and 21,106 adults in *GAMC*. Overall, there are 126,420 persons enrolled in MinnesotaCare -- all categories.

Program Administration: MinnesotaCare is administered by the Minnesota Department of Human Services. MinnesotaCare operated originally as a fee-for-service program. By January 1997, all enrollees were transferred to managed care health plans.

GAMC is administered locally by counties, under the oversight of the Minnesota Department of Human services. The county human service agencies handle eligibility determination and enrollment. Health care is provided either fee-for-service or through prepaid health plans, depending on the county of residence.

Cost Experience: Cost information provided by the staff of Minnesota's Department of Human Services indicates that the average monthly per capita *cost* for childless adult enrollees for calendar year, 2001 is as follows:

	Per Member Per Month	Projected Total Expenditure
MinnesotaCare	$316.64	$71.5 million
GAMC	$419.21	$63.8 million

Funding Mechanisms: As indicated above, Minnesota receives no federal cost sharing for coverage of childless adults. MinnesotaCare is financed with enrollee premiums, and a tax on health care providers.

GAMC is funded with state general fund dollars.

Oregon Health Plan (Oregon)[12]

In 1995 Oregon received an 1115 waiver to: 1) expand eligibility, 2) develop a prioritized list of health care benefits, and 3) enroll most beneficiaries in managed care plans. In 1998, Oregon obtained a 3-year extension for the demonstration, which will now continue through January 31,2002. Cost savings from managed care; premiums; general revenue; and a voter-approved tobacco tax earmarked for the expansion programs have financed the cost of expanding eligibility.

Eligibility: Adults aged 19 or over and not Medicare eligible with income below 100% FPL who do not meet one of the other Medicaid eligibility classifications, and do not have an unborn child or a child under age 19 in the household. *Must be uninsured to enroll.*

Benefits: Same as for rest of Medicaid population, including:

- Preventive & acute physical care
- Hospitalizations
- Pharmaceuticals
- Mental Health/Substance Abuse
- Dental, including preventive and restorative
- Vision & glasses
- Hospice

Excluded: Long-term care services; retroactive eligibility/payments

Program size: In March 2001, there were 47,381 non-parenting adult enrollees, representing approximately 13 percent of Oregon's entire Medicaid population.

Program Administration All enrollees must enroll in a fully capitated managed care plan (approximately 81 percent of enrollees) or a Fee-For-Service Primary Care Case Manager program (19 percent). FFS/PCCM enrollees tend to live in rural areas.

Premiums: $6 to $28 per month depending on income; premiums average $11 per month.

Recertification: Every 6 months.

Cost experience: Current costs in Oregon are:
persons in capitated managed care plans: $287.27 per person per month.
persons in fee for service PCCM: $338.47

Vermont Health Access Plan[13]

The Vermont Health Access Plan (VHAP) is designed to provide health care coverage through managed care to adults, and to parents and/or caretaker relatives who otherwise would be uninsured. State coverage of adults began in March, 1997.

Eligibility: Uninsured adults who are not parents or caretakers with incomes up to 150 percent FPL are eligible. The income threshold for parents or caretakers is 185 percent FPL. There are no categorical requirements or asset tests. VHAP-limited provides a restricted insurance benefit until participating individuals can be enrolled in managed care. Enrollees must be uninsured and there is a 12 month wait for eligibility for persons who had prior coverage, unless they lost coverage involuntarily (e.g., their employer dropped health benefits).

Benefits: Enrollees are provided with a benefit package similar to a comprehensive commercial health coverage plan. Long-term mental health care is carved out. Nursing home coverage is provided for up to 30 days. Home health benefits are unrestricted.

Program Size: As of March, 2001, there were 16,699 enrollees in VHAP and 2,715 in V W-limited.

Program Administration: The Office of Vermont Health Access (OVHA) within the Department of Prevention, Assistance, Transition, and Health Access (PATH) -- formerly the Department of Social Welfare -- is responsible for overall administration of all health access programs including Medicaid, SCHIP and the 1115 waiver programs. OVHA contracts out several key functions related to the health service management: prior authorization, concurrent review and external quality review is contracted to an outside organization; claims processing and provider support is contracted to a different external organization; and enrollment and member services is also externally managed through a contract organization.

Health care to enrollees is provided through a primary care case management system -- *Primary* Care Plus -- that is administered by the state with assistance from outside contractors, as specified above. This system operates as a primary care physician gate-keeping system. PCPs are paid a monthly administrative fee for each beneficiary in their practice, and reimbursed, FFS in accordance with the Medicaid fee schedule for services rendered.

Program funding: VHAP is a HCFA approved Medicaid expansion under an 1115 waiver and thus, the program is a shared federal/state funded program. The overall OVHA budget, covering all programs under the Medicaid umbrella plus SCHIP, for FY 2001 is **$388,766,333** of which **$148,089,410** is State General Funds and **$240,676,410** is federal Medicaid dollars. The State General Fund allocation includes $21,802,653 from a cigarette tax. In addition, **$2.883** million from the tobacco settlement has been added to the VHAP Trust Fund for SFY '01.

Vermont applied for and received an 1115 waiver in 1995 to obtain authorization to expand coverage to uninsured adults and to provide pharmacy assistance to low-income elderly or disabled citizens. Vermont's determination of budget neutrality is based on per capita expenses, not total program costs. This approach holds the state harmless for cost increases due to increased enrollment, but requires the state to keep growth trends, in per person spending below historical trend rates. To date, because the state has implemented its PCCM system, its cost experience has been positive, with a projected **$4.42** million surplus by the end of the waiver period. However, this projection represents less than 1% of total waiver expenditures over the eight year period, so the margin of error is very small. The structure of the waiver limits state flexibility in negotiating rate changes with providers and may require the state to limit benefits in the future, to reduce average costs per person.

Premiums: An enrollment fee between **$10** and **$25** per adult is charged for each 6-month enrollment period. These fees apply to eligibles between 50% and **185%** of the federal poverty level. Persons with incomes below 50% FPL do not pay a fee. Enrollees are subject to service-specific cost-sharing up to an annual out-of-pocket maximum of **$750** per person per year.

Recertification: Every **6** months.

Outreach: Responsibility for outreach is contracted to an outside agency. This agency employs two outreach specialists who hold informational meetings in various locations and times across the state. These specialists will also assist individuals with the application process at community informational meetings, and can direct persons to the appropriate state program for which they might be eligible.

Cost **Experience:** Based on current fiscal year budget amounts and current enrollment levels, Vermont cost per person enrolled in the adult VHAP program can be estimated at **$166.84** per person per month.

Adverse Selection: Although no formal study has been undertaken, the impression of program administrators in Vermont is that VHAP has not experienced adverse selection. Costs per person are not substantially higher than other persons enrolled in the *PrimaryCare Plus.*

VI. Estimated Program Costs

The cost to Maine of extending coverage to currently uninsured, low-income and childless adults would be affected by many aspects of program design not yet specified by the Legislature. The scope of benefits, obviously, could substantially alter average per person cost. The introduction of premium payments -- even at very low levels -- can alter rates of enrollment and change the mix of enrollees. Additional cost sharing in the form of copayments or deductibles would not only offset state costs but might change utilization patterns.

Allowing individuals to enroll who met income eligibility but who had alternative health coverage (i.e., would use state coverage for wrap-around benefits) would impact both the size of enrollment and average per person costs. The aggressiveness of program outreach could impact on the "risk selection" of enrollees. A more passive approach to the program might attract a larger proportion of currently ill individuals, while an active outreach program might draw in more currently healthy individuals. Use of managed care service arrangements could also affect costs. For example, Maine Primecare is the Medicaid Program's statewide primary care case management initiative with a current enrollment of 90,000. Enrollment of new program Participants into Maine Primecare or another managed care arrangement could significantly alter costs.

Finally, factors external to the program can alter eligibility estimates and participation rates. If Maine's economy slows and commercial health care costs continue to rise, the number of uninsured -- particularly in the 100% to 150% FPL income range -- could grow substantially.

In surveying other programs, we found no uniformity with regard to benefits, eligibility criteria, or program operations. Thus, we are left with a wide range of cost experiences and insufficient grounds for applying any of these experiences to a proposed Maine program. We offer a range of cost estimates, all within the parameters experienced by other states, but providing a "low" and a "high" estimate to allow for future decisions regarding program specification. The cost experiences of Delaware, Oregon, Minnesota and Vermont were used to set parameters because these four states were able to separate out the costs of adults from other covered populations. It should be noted that all these states offer very comprehensive, rich benefit packages that include substantial coverage of prescription drugs, and various other non-traditional benefits in the commercial market such as dental, some nursing home care, eye-glasses, hearing aids or home health care. The year 2001 per person per month costs for these plans were $167 for Vermont, $250 for Delaware, $287 for Oregon, and $317 for Michigan. Based on these states' experiences, we used $200 per person per month as a minimum expected cost per person. We used $350 as a high cost estimate.

Another factor affecting cost estimates is the expected participation rate among eligible persons. Again, the experience of other states varies widely. We selected, as benchmarks, three states that have separate programs targeted to childless adults and can provide estimated participation rates for this group. Delaware's estimated participation rate for this population is 34%, Vermont's is 22%, and Hawaii's[14] is 41%. We have developed program cost estimates for two scenarios: a participation rate of 20% and a participation rate of 45%.

The table below shows estimated annual costs for programs with eligibility thresholds at 125% FPL and 150% FPL, with adjustments both for low and high enrollment estimates, and low and high cost estimates.

Several assumptions regarding these cost estimates should be noted. First, these costs were developed from programs that enroll only the currently uninsured and do not allow persons with alternative coverage to enroll and "wrap around" their other coverage. Thus, were the Maine legislature to consider this additional eligibility group, cost estimates would need to be increased to accommodate this additional enrollment group. Second, the programs used as benchmarks include limited, if any nursing facility or intermediate facility benefits. Therefore, should the legislature contemplate a benefit package that encompassed these benefits, separate cost estimates would be needed for these benefits.

Cost Estimates for Program with 125% FPL Eligibility Threshold

	Estimated Participation	Estimated Per Member Per Month cost	Annualized Costs
Low Participation Low cost	3,792	$200.00	$9,100,800
Low Participation High Cost	3,792	$350.00	$15,926,400
High Participation Low cost	8,532	$200.00	$20,476,800
High Participation High Cost	8,532	$350.00	$35,834,400

Cost Estimates for Program with 150% FPL Eligibility Threshold

	Estimated Participation	Estimated Per Member Per Month cost	Annualized Costs
Low Participation Low cost	4,648	$200.00	$11,155,680
Low Participation Low cost	4,648	$350.00	$19,522,440
High Participation Low cost	10,458	$200.00	$25,100,280
High Participation High Cost	10,458	$350.00	$43,935,490

VII. Federal Cost Sharing

Access initiatives that are approved as Medicaid expansions by the federal Health Care Financing Administration (HCFA) qualify for federal matching dollars at a state's Medicaid match rate. This strategy, obviously, where possible, is the least costly way for a state to expand coverage.

Section 1115 (a) gives HCFA the flexibility to approve coverage of non-traditional populations as long as two conditions are met: quality of care for beneficiaries is not compromised and the waiver is budget neutral to the federal government. HCFA negotiates the terms of budget neutrality with states based on trending a state's historic costs forward, to estimate what "would have been spent" in the absence of the waiver. Budget neutrality may be determined in either of two ways: *total program costs* or *per capita costs*. The program total methodology looks at annual expenditures, regardless of enrollment changes. The per capita methodology looks at cost per person, holding the state harmless for enrollment increases, but holding the state to a rate of expenditure per person based on historic costs.

Each approach has liabilities and advantages for a state. Total program expenditures work to a state's advantage if gains in the economy reduce the need for public assistance and perhaps creates greater flexibility in changing program parameters. However, should the economy soften and enrollment increase, budget neutrality may be hard to maintain without reducing enrollment eligibility or cutting provider reimbursement rates. Conversely, per capita neutrality makes it difficult for a state to absorb unexpected medical cost increases -- for example, substantial increases in the cost of prescription drugs -- without reducing services or reimbursement rates to providers.

HCFA caps the federal contribution to 1115 waiver demonstration programs at the cost neutral amount approved in states' applications. Should a state fail to meet cost neutrality after the demonstration is implemented, program costs above the approved amount are not offset by federal matching dollars. Thus, cost overruns are a state-only liability.

States that have used the 1115 waiver to expand coverage to non-custodial adults have used both cost neutrality strategies. Vermont obtained an 1115 waiver using the per capita cost neutrality approach. The state's recent shift to placing almost all covered persons into a primary care case management system may have helped the state in maintaining cost neutrality under this approach.

States that have used the total program cost neutrality strategy while expanding coverage to new populations have done so primarily through showing savings from managed care implementation, the imposition of cost sharing by beneficiaries, and offsets in cost through unspent disproportionate share hospital allocations (DSH). HCFA has approved 1115 waivers in at least seven states that have used their unspent DSH allocations to help reach cost neutrality.

Maine's 2001 DSH allocation is $84 million, while the state only expects to spend $32 million of this amount to provide services in its psychiatric facilities. The remaining $52 million might be explored as an option for negotiating a plan of budget neutrality with HCFA, should the state decide to pursue an 1115 waiver to cover uninsured adults.

Were a waiver attained, the state share of the program costs estimated above would be limited to 33.42% of program costs, with the federal government contributing 66.58%. Maine's costs would thus range annually from $3,041487 to $11,975,856 for the program with a 125% FPL threshold, according to our estimates. And annual estimates range ftom $3,728,228 to $14,679,898 for the program with eligibility up to 150% FPL.

It is important to note that Maine cannot use unexpended DSH dollars as funding toward the state's portion of program costs. Savings from unexpended DSH dollars accrue to the federal government. Thus, the Maine cost of these programs, whether $3 million or $15 million, would have to be appropriated by the Legislature from the state general fund or ftom new taxes.

END NOTES

[1] Overall, in 1999 the national uninsurance rate was 15.5 percent, while the Maine rate was 11.9, according to national Census data, Therefore, applying national rates to specific groups of low-income persons within Maine may over-estimate the number of uninsured. Lacking state-specific data, this approach was used to develop rough estimates which, we felt, erred on the side of caution in that they may overstate the extent of need.

[2] Information on numbers and types of federally sponsored health care providers from: U.S. Department of Health and Human Services, Bureau of Primary Health Care, Uniform Data System, (1998).

[3] Source: Maine Department of Human Services Bureau of Health, ***Maine Health 2000: A Health Planning Resource, (2000).***

[4] ***The Cost of Health Care In Maine: Report of the Year 2000 Blue Ribbon Commission on Health Care.*** Available through the Maine Development Foundation, Augusta Maine. (2006).

[5] Report from Families USA based on analysis of the national Medical Expenditure Survey, Agency for Health care Research and Quality, HHS. **(2000).**

[6] Ormond, C., Salley, S., Kilbreth, E., ***Profiling Uninsured persons in Three Maine Counties: MaineHealth Access Project*** A Report prepared for MaineHealth by the Institute for Health Policy, Muskie School, University of Southern Maine, Portland Maine. (2000).

[7] The Behavioral Risk Factor Surveillance System (BRFSS) is an on-going data collection program administered by the National Center for Chronic Disease Prevention and Health Promotion, within CDC. CDC developed a standard core questionnaire and states, which administer the survey, can add questions of particular relevance to their population. Since 1994, all states, the District of Columbia, and three territories have participated in BRFSS. See http://www.cdc.gov/nccdphp/brfss/about.htm.

[8] Data from the Behavioral Risk Factor Surveillance System, 1996-1997, as reported in ***Greater Portland Community Health Assessment and Source Book 2000,*** Greater Portland Partners for Health. (2000).

[9] All figures in this section drawn from ***The Cost of Health Care in Maine: Report of the Year 2000 Blue Ribbon Commission on Health Care, (2000).***

[10] Information on the Diamond State Health Plan taken from the HCFA Fact Sheet "Delaware Statewide Health Reform Demonstration"; the Delaware state website (http://www.state.de.us/dhss/dss/dsshome.htm); and from a telephone interview with Philip P. Soule, Sr., Deputy Director of the Delaware Medicaid program.

[11] Information on Minnesota's coverage program taken from the Minnesota Health Reform Demonstration fact sheet, www.hcfa.gov/medicaid/1115/mnfact.htm; About MinnesotaCare, www.dhs.state.mn.us/hlthcare/AsstProg/mncare/default.htm; and from documentation provided by Minnesota DHS officials.

[12] Information on the Oregon Health Plan taken *from* ***Progress Report: Oregon Department of Human Services*** (October, ***2000);*** "Office of Medical Assistance Programs Fact Sheet"; the ***OHP*** website (http://www.omau.hr.state.or.us); and from communications with program staff.

[13] Information on the Vermont Access Plan taken from the Office of Vermont Health Access Annual Report ***(2000);*** from the Vermont PATH website (www.state.vt.us); and from telephone interviews with Vermont state officials.

[14] Because Oregon and Minnesota enrolled non-parenting adults as part of larger, comprehensive access initiatives, estimated participation rates for the sub-set of non-parenting adults are not available. The participation experience of the Hawaii program for this population of adults is reported here to add an additional data point and to strengthen basis for developing Maine estimates. A brief summary of the Hawaii program is included in Appendix D.

Appendix A:
Adults in Maine Without Dependent Children by Income and Age

	Male		Female		Total		Total
	Age 21-44	Age 45-64	Age* 21-44	Age 45-64	Age 21-44	Age 45-64	All Ages
<100% FPL	5,910	4,396	6,425	6,780	12,335	11,176	23,511
100-124 FPL	1,787	1,981	1,911	2,962	3,698	4,943	8,641
125-149 FPL	2,138	2,124	2,935	2,759	5,073	4,883	9,956

Cumulative Totals:
<100% FPL 23,511
<125% FPL 32,152
<150% FPL 42,108

* Population estimates for females in this age group have been adjusted downward by 5% to account for the proportion of women pregnant over the course of a year who would (in these income groups) be eligible for Medicaid coverage and, thus, ineligible for the program under consideration.

Source: U.S. Census Bureau, 1990 Census

Appendix B
Maine's Federally Qualified Community Health Centers
Population Served, 1998

Number of federal grantees: 7

Number of health center sites: 26

Vulnerable Populations	Maine Statewide Total	Health Center Population	Population Served as Percent of State Total
Total Maine Population	1.2 million	2,059	[illegible]%
[illegible] persons	134,000	16,773	12.5%
CHILDREN			
0-100% FPL	42,000	6,892	16.4%
101-200% FPL	64,414	10,821	16.8%
ADULTS			
0-100% FPL	66,000	11,881	18.0%
101-200% FPL	[illegible]	13,257	8.3%

Note: Population figures by income level include persons with insurance. Many children with incomes below 100% FPL, for example, may have Medicaid coverage.

Source: National Association of Community Health Centers, Inc. 1999 www.nachc.com

Appendix C
1999 Expenditures, Out-of-Pocket Payments, and Charity Care Services for Maine's Uninsured Population

	Expenditures Total	Portion paid Out-of-Pocket	Portion Covered Through Bad Debt or Charity Care
Hospital Services	$115,073,252	$10,073,252	$105,000,000
Physician Service	$77,015,199	$38,507,600	$38,507,599
Drugs and Medical non-durables	$34,742,400	$34,742,400	$0
All Other Health Services	$43,821,741	$23,783,710	$20,038,031
Total	$270,652,592	$107,106,962	$163,545,630

Source: *The Cost of Health Care in Maine: Report of the Year 2000 Blue Ribbon Commission on Health Care*

***Appendix D*:**
State Coverage of Uninsured Adults Program Summary

State	Year Established	Age Eligible	Income Eligible	Estimated Participation Rate	Program Description	1115 Waiver Y/N
DE	1996	19-64	100% FPL	34%	Medicaid expansion. Health services through managed care contracts. Outreach and enrollment through contracted Health Benefits manager. Full subsidy for persons below 100% FPL.	Y
HI	1994	0-64	100% FPL	41%	Managed care for uninsured individuals with incomes below 100% FPL (Hawaii has mandated employer coverage for full-time employees). Covers single adults, childless couples, unemployed individuals, part-time workers, self-employed and seasonal workers. Eligible self-employed must pay half the premium amount.	Y
MA	1990	0-64	133% FPL	10%	A complex collection of programs targeted to: persons receiving unemployment compensation, some families below 200% FPL, and some chronically unemployed adults and individuals without children up to 133% FPL.	Y
MN	1992	0-64	175% FPL	50%*	Minnesota covers adults both through the MinnesotaCare program and a General Assistance program. MinnesotaCare is administered by DHS which contracts with managed care organizations. GMAC is county administered with state dollars.	N
MO	1999	21-64	125%FPL	NA	Covers certain uninsured, non-custodial parents .	

State	Year Established	Age Eligible	Income Eligible	Estimated Participation Rate	Program Description	1115 Waiver Y/N
NJ	1995	0-64	<150% FPL	3%	Financial assistance to families to purchase commercial insurance. Choice of five managed care or one indemnity plan. Individuals pay between $5 and $170 per month depending on income.	
OR	1994	19-64	<100% FPL	50%*	Managed care for all state residents with incomes below 100% FPL. Individuals pay $6 per month toward coverage.	Y
TN	1994	0-64	No limit for uninsured not qualified for Medicaid	26%*	Managed care contracted through ten managed care organizations. Enrollment is currently frozen for non-Medicaid uninsured with 1.3 million in program. Persons with incomes below poverty are fully subsidized. Those between 100% and 200% FPL pay premiums from $14-$33 per month, and between 200-300 FPL pay premiums from $74-$81 per month.	Y
VT	1900	18-64	<150%	22%	Medicaid-administered managed care coverage for previously uninsured adults with incomes <150% FPL. Contracted outreach and enrollment. Individuals between 100-150% FPL pay monthly premium of $2 to $3.	Y
WA	1[illegible]9	0-64	No limit	19%*	Coverage through managed care organizations. Sliding scale premium payments based on income. Available also as group coverage to employers, with subsidies for low-income employees. Premiums range from $10 per month for persons below poverty to $190 per month for non-subsidized. **	N

Information from:

[1] Summer, L. *The improving health care coverage and affordability series.* American Academy of Aging (1998). Available online at the Commonwealth Fund: www.cmwf.org/programs/insurance/sum260_tables.asp.

[2] Lipson, DL and Schrodel, SP. *State-subsidized insurance programs for low-income people.* Alpha Center (1996).

* Participation estimates for program as a whole -- not just childless adults.

** Premium figures for 1997.

Attachment C

Benefit Package Description

The State of Maine intends to begin the program by providing the same benefit package available under the Medicaid Program. After assessing expenditures, the State may choose to reconfigure the benefit package to be equivalent to the package provided to State employees.

1. Attachment 3.1A to the State Plan

2. State Employee Health Plan

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: [X] No limitations [ ] With limitations*

2.a. Out patient hospital services

Provided: [X] No limitations [ ] With limitations"

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

Provided: [X] No limitations [ ] With limitations"

[ ] Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: [X] No limitations [ ] With limitations*

3. Other laboratory and x-ray services.

Provided: [X] No limitations [ ] With limitations*

*Description provided on attachment.

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: [X] No limitations [ ] With limitations*

b. Early and periodic screening, diagnostic and treatment services for individual under 21 years of age, and treatment of conditions found."

c. Family planning services and supplies for individuals of child-bearing age.

Provided: [X] No limitations [ ] With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: [X] No limitations [ ] With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: [X] No limitations [ ] With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: [ ] No limitations [X] With limitations* [ ] Not provided.

*Description provided on attachment.

State: Maine

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED OT THE CATEGORICALLY NEEDY

Item 6b - Optometrists Services

Limited to one pair of eyeglasses when the power is equal to or greater than 10.00 diopters. Individuals covered under EPSDT are eligible to receive other services subject to the following limitation: examination and eyeglasses may only be provided for more than minor refractive error. The volume purchase of eyeglasses limited the selection of frames and lenses to a basic assortment from one supplier.

Item 6c - Chiropractor's Services

Limited to treatment by means of manual manipulation of the spine.

Item 6d - Other Practitioners' Services:

Psychologists

Psychologist services are limited to those provided by a licensed psychologist. Staff operating under the direction of a licensed psychologist may be reimbursed for neuropsychological testing when performed by appropriately educated and/or trained staff.

Limited to evaluation, individual or group psychotherapy, psychometric testing, pain management services for approved programs and collateral contacts. Limited to two hours per week for individual psychotherapy unless emergency treatment is required and in then limited to eight visits per emergency. Limited to ninety minutes per week for group therapy with exceptions of patients in an inpatient psychiatric facility or individuals in groups for trauma treatment. Psychometric testing is limited to a total of four hours except for the Halstead-Reitan Battery (seven hours) Intellectual Level (two hours) and self administered tests (thirty minutes).

Psychological Examiners

Limited to psychometric testing of four hours except for the Halstead-Reitan Battery (seven hours) Intellectual Level (two hours) and self administered tests (thirty minutes), and intervention services defined as consultation, behavior management and social skills training.

Licensed Clinical Social Workers and Licensed Clinical Professional Counselors

Services covered for children up to age 21.

Advanced Practice Nurses other than nurse midwives and certified family and pediatric NPs

No limits

State/Territory: Maine

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED OT THE CATEGORICALLY NEEDY

Item 6a. Podiatrists' Services

Limited to non-routine procedures only, treatment of plantar warts, ingrown nails, ulcerations, bursitis, and infections of the foot, and minor surgical procedures under local anesthesia. Also, **some** routine procedures complicated by foot pathology (such as nail-clipping if severe diabetes with onychomyocosis) are covered.

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

c. Chiropractors' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

d. Other practitioners' services.

[X] Provided: Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

7. Home Health services.

a. Intermittent or part-time nursing services provided by a licensed and Medicare certified home health agency.

Provided: [ ] No limitations [X] With limitations*

b. Home health aide services provided by a licensed and Medicare certified home health agency.

Provided: [ ] No limitations [X] With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: [ ] No limitations [ ] With limitations*

d. Physical therapy services provided by a licensed and Medicare certified home health agency.

Provided: [ ] No limitations [☒] With limitations*

e. Speech-language pathology services provided by a licensed and Medicare certified home health agency..

Provided: [ ] No limitations [☒] With limitations*

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitationfacility.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] **Not** Provided.

8. Private duty nursing services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

State/Territory: Maine

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED OT THE CATEGORICALLY NEEDY

7. Home Health Services

Prior authorization for services is required in order to continue services after the initial certification period, except for: A) psychiatric medication administration and monitoring (exempt), and B) a limited number of physical, occupational and speech language therapy visits per state fiscal year. Additional therapy visits can be obtained with prior authorization.

8. Private duty nursing services.

These nursing services are those provided by a licensed home health agency or an independent professional registered nurse. Private duty nursing services are provided under the direction of the client's physician. Some services require prior authorization by the State Agency or its authorized agent. Services are limited to an annual or monthly cap according to the level of care, as determined by the State Agency. Home Health nursing and aide services shall count toward the cap. Individuals under the age of 21 may be eligible for any level of Private Duty Nursing Services. Individuals age 21 and over may be eligible for only the following: "At Risk Level, "Extended" Level of Service, "Venipuncture Services", or the "Medication and Venipuncture Services".

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not Provided.

10. Dental services

[ ] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

11. Physical therapy and related services

a. Physical therapy

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not Provided.

b. Occupational therapy

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

c. Services for individuals with speech, hearing, and language disorders (provided y or under the supervision **of** a speech pathologist or audiologist).

[X] Provided: [X] No limitations [ ] With limitations*
(See Attachment **3.1-A,** p.4a)

[ ] Not Provided.

*Description provided on attachment.

State/Territory: Maine

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Item 10. Dental Services

A. Persons under **EPSDT** not limited, except that PA is required for orthodontic services and some others.

B. For persons aged 21 years of age and over limited to:

1. acute surgical care directly related to an accident where traumatic injury has occurred;

2. diagnostic procedures to identify the acute problem;

3. medications necessary to eliminate infection and control acute pain;

4. pulpotomies, and root canal treatments for acutely painful teeth;

5. restorations necessary to restore previously endodontically treated teeth during the same period of treatment as the original endodontic services;

6. restorations necessary to prevent eminent tooth loss;

7. extraction of teeth as necessary to treat acute pulpitis or acute periodontal abscess;

8. extraction of teeth when provided in connection with medically necessary oral surgery, or when radiographic evidence indicates tooth decay into the pulp or periapical bone loss; and

9. oral surgical and related medical procedures not involving the dentition and gingiva.

Item 11b. Occupational Therapy Services shall be provided by or under the direct supervision of a licensed Occupational Therapist.

Item 11c. Speech and Hearing Services

Hearing aids and hearing aid examinations are not covered for persons aged 21 years and over. Covered for persons under **EPSDT**

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

b. Dentures.

[X] Provided: [ ] No limitations [ ] With limitations*

[ ] Not Provided.

c. Prosthetic devices.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not Provided.

d. Eyeglasses.

[X] Provided: [ ] No limitations [ ] With limitations*

[ ] Not Provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

*Description provided on attachment.

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY
NEEDY

Item 12a Prescribed Druas

Limited to prescribed medications, but including certain prescribed over-the-counter drugs. Some drugs require prior authorization.

Item 12b Dentures

Limited to permanent dentures, with prior authorization required for partial dentures. Individuals age 21 and over with qualifying medical conditions, submitting requests for prior authorization, will be considered for full and partial dentures or other appropriate dental services under the adult dental services criteria. Prior to approving adult dental services the department determines that the provision of those services is medically necessary to correct or ameliorate an underlying medical condition, and will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition.

Item 12d Evealasses

Limited to first pair of eyeglasses for individuals not covered under EPSDT when the power is equal to or greater than +10 diopters. The volume purchase of eyeglasses limits the selection of frames and lenses to a basic assortment from one supplier.

Item 13a. Diagnostic Services

Covered diagnostic services are limited to those services provided by mental health facilities licensed by the Department of Mental Health and Mental Retardation and recommended by a physician or other licensed practitioner of the healing arts.

Item 13b. Screening Services

Covered services are limited to V.D. Screening Clinic Services which include screening for sexually-transmitted diseases, cost and administration of medication, follow up and counseling.

Item 13c. Preventive Services

Covered preventive services are limited to services provided by mental health facilities licensed by the Department of Mental Health and Mental Retardation and delivered by a staff member who is a licensed practitioner of the healing arts within the scope of his/her practice under State law.

Item 13d. Rehabilitative Services

Rehabilitative Services are limited as follows:

1. Private non-medical institutions for substance abuse treatment, mental health services, child-care services, and services for people with mental retardation. Covered services include only detoxification, rehabilitation, extended care, extended shelter, halfway house, mental health and child-care services, provided to residents by qualified staff. These services may be provided by physicians, psychologists, psychological examiners, dentists, R.N.'s, L.P.N.'s, speech therapists, and other substance abuse counselors, M.S.W.'s, occupational therapists, and other qualified staff carrying out a written plan of care. Such plans of care or initial assessments of the need for services are recommended by a physician or other licensed practitioner of the healing arts. Covered Services also include administrative costs related to the provision of direct services.

2. Mental Health Services. Covered services include rehabilitation and community support services provided by staff of mental health facilities licensed or approved by the Department of Mental Health and Mental Retardation. These services may be provided by physicians, psychologists, psychological examiners, MSW s, psychiatric nurses, and qualified mental health staff carrying out a plan of care. Certain crises-oriented services may be provided to individuals under age 21 as home based mental health by facilities licensed by the Department of Mental Health and Mental Retardation.

3. Substance Abuse Treatment Services. Covered services include only those evaluation and clinical services provided under the direction of a physician or psychologist and delivered by qualified staff of an outpatient andlor on-residential facility certified as such by the Office of Alcoholism and Drug Abuse Prevention for the rehabilitation of substance abuse.

4. Day Health Services. Covered services are available for individuals requiring assistance with ADL's.

Item 13d. Rehabilitation Services (Cont.)

5. Rehabilitative Services. Covered services are available for individuals having a traumatic brain injury.

6. Early Intervention Services - are covered treatment services which are designed to enhance the development of children who have or are at risk for disabilities.

Environmental Investigations in Cases of Confirmed Lead Poisonina in a Child. Covered services include environmental investigations and lab analysis of soil, water and dust in primary and secondary dwellings and/or the land surrounding them.

8. School-Based Rehabilitative Services. Covered services include only those services referred by a Pupil Evaluation Team and included in an Individual Education Plan or an integral part of a program included in an Individual Education Plan or an evaluation necessary to determine the need for or scope of an Individual Education Plan. School-Based Rehabilitative Services commonly include a mixture of individual, group, and activities therapies and may also include therapeutic treatment oriented toward minimizing the effect of a child's disabling conditions(s) and/or to enhance or restore a child's physical or mental ability. These services may be provided by or under the supervision of a licensed practitioner of the healing arts within the scope of his or her practice under State law or other qualified staff authorized by the Maine Department of Education.

9. Residential Services – are covered medical or remedial services when determined to be necessary by a physician or other licensed practitioner of the healing arts.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

c. Preventive services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

d. Rehabilitative services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

[X] Provided: [X] No limitations [ ] With limitations"

[ ] Not Provided.

b. Skilled nursing facility services.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not Provided.

c. Intermediate care facility services.

[ ] Provided: [ ] No limitations [ ] With limitations"

[ ] Not Provided.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☐ Provided: ☒ No limitations ☐ With limitations*

☐ Not Provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not Provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not Provided.

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not Provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not Provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations [ ] Not provided

b. Special tuberculosis (TB) related services under Section 1902(z)(2)(F) of the Act.

[ ] Provided: [ ] With limitations [X] Not provided

20. Extended services to pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

[X] Provided: [ ] Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

[X] Provided: [ ] Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility periods by an eligible provider (in accordance with section 1920 of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided

23. Certified pediatric or family nurse practitioners' services.

Provided: ☒ No limitations ☐ With limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation:

[X] Provided: [ ] No limitations [X] With limitations*
(See Attachment to Attachment 3.1-B, Page 8)

[ ] Not Provided

b. Services provided in Religious Nonmedical Health Care Institutions

[X] Provided: [X] No limitations [ ] With limitations"

[ ] Not Provided

c. Reserved

d. Nursing facility services for patients under 21 years of age.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not Provided

e. Emergency hospital services.

[ ] Provided: [ ] No limitations [ ] With limitations"

[X] Not Provided

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not Provided

g. Clozaril Monitoring Services

[ ] Provided: [ ] No limitations [ ] With limitations"

[X] Not Provided

*Description provided on attachment.

State/Territory: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL SERVICES
AND CARE PROVIDED TO THE CATEGORICALLY

24f - Personal Care Services

Except as noted below personal care services are those services provided by a home health aide or certified nurses' aide and which are delegated and supervised by a registered nurse. These services must be prescribed by a physician in accordance with the client's plan of care. Individuals under the age of 21 may be eligible for any level of Personal Care Services. Individuals age 21 and over may be eligible for only the At Risk Level or the Extended level of Services. Individuals age 21 years and over shall receive a medical eligibility determination by the Department's authorized Assessing Services Agency. Medicaid covered services in the plan of care shall be prior authorized, coordinated and monitored by the authorized Home Care Coordinating Agency.

Personal care services in Private Non-Medical Institutions are provided by qualified medical and remedial services facility staff, other qualified mental health staff and qualified personal care service staff and are supervised by a registered nurse. Services must be prescribed by a physician in accordance with the client's plan of care.

State: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL SERVICES AND CARE PROVIDED TO THE CATEGORICALLY

25. Home and Community care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided ☐ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician or the State Agency or its authorized agent in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☐ Provided

☒ State approved (not physician) service plan allowed

☒ Services outside the home also allowed

☒ Limitations described on attachment

☐ Not Provided

State: Maine

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL SERVICES AND CARE PROVIDED TO THE CATEGORICALLY NEEDY

26. Except as noted below personal care services are those services provided by a home health aide, certified nurse aide or a personal care assistant. Services provided by a Home Health aide or Certified Nurse aide are delegated and supervised by a registered nurse. The services must be provided under an authorized plan of care. Services for clients age 21 and over require prior authorization by the state Agency or its authorized agent. Services are limited to an annual or monthly cap, according to the level of care as determined by the State Agency. Home Health nursing and aide services count toward the cap. Individuals age 21 or over may be eligible for only the "At Risk" level or the "Extended" level services. Assistance may be provided outside the home setting, as authorized in the plan of care.

Personal care services in Private Non-Medical Institutions are provided by qualified medical and remedial services facility staff, other qualified mental health staff and qualified personal care service staff and are supervised by a registered nurse. Services must be prescribed by a physician and delivered in accordance with a plan of care.

Consumer directed personal care services are provided only to individuals who are able to self-direct a personal care attendant and who have chronic physical condition that requires a assistance with a minimum of two Activities of Daily Living. The consumer must be his or her own guardian. Each individual is eligible for personal care services as the State Agency or its Authorized Agent determine are necessary, and authorize in a plan of care, up to a maximum of thirty-five (35) hours per week of attendant services, plus up to two hours per night of additional service. Assistance may be provided outside the home setting, as authorized in the plan of care. PCAs must be at least 17 years old.

CASE MANAGEMENT SERVICES

A. Target Group:

Mentally retarded adults who are age 21 or older and who meet the eligibility requirements of Title 348, M.R.S.A. §5001 which defines mental retardation as a condition of significantly subaverage intellectual functioning manifested during a person's developmental period, existing concurrently with demonstrated deficits in adaptive behavior. Clients in an intermediate care facility for the mentally retarded will not be eligible for case management services.

B. Areas of State in which services will be provided:

/X/ Entire State, with the exception of the areas covered by Target Groups identified in A(8), A(12) and (14).

/ / Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

C. Comparability of Services

/ / Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services include client intake and assessment, plan of care development, service coordination and advocacy, monitoring of the client and evaluation of the appropriateness of the plan of care.

E. Qualification of Providers:

1. Mentally Retarded Adults

Case management services will be provided by approved staff of agencies designated and licensed by the Department of Behavioral and Developmental Services. Approved staff include; (Cont.)

A. Target Groups: (Cont.)

2. Covered services will be provided to people who are diagnosed with Human ImmunodeficiencyVirus infection or with AIDS-Related complex or with AIDS.

3. Children, age 0-5, who are developmentally disabled or who demonstrate developmental delays or who are at risk for developmental delays.

4. Covered services will be provided to families who children are abused or neglected or suspected to be at risk thereof.

5. Covered services will be provided to children and young adults who are in the care or custody of the Department of Human Services or of an agency in another state and placed in Maine, and families of children who are receiving post adoption services.

6. Covered services will be provided to adults who are in need of protective services provided by the Department of Human Services.

7. Children and adolescents age through-20 years of age, who have been diagnosed as having an emotional disturbance, at risk of a mental impairment, emotional or behavioral disorder or has been determined to have a functional impairment.

8. Covered services will be provided to children and adolescents ages 11 – 17 with serious emotional disturbance who reside in Cumberland County.

9. Covered services will be provided to juveniles on probation (referred or under the supervision of juvenile caseworkers).

10. Covered services will be provided for pregnant andlor postpartum women andlor those at risk of inadequate parenting.

11. Covered services will be provided for adults with long term care needs.

12. Covered services will be provided to eligible recipients living in Somerset, Cumberland, Androscoggin, Oxford, Kennebec, Waldo, Penobscot, Sagadahoc, Knox, York and Lincoln Counties who have at least one child under the age of 16 and are homeless or at risk of homelessness.

13. Covered services will be provided to persons who have been diagnosed as having psychoactive substance-abuse dependence, or who are currently receiving active substance-abuse treatment or individual/group follow-up or after-care services.

14. Covered services will be provided to eligible recipients living in Kennebec, Somerset, Franklin, Oxford, Androscoggin, Sagadahoc, Waldo, Penobscot, Knox and Lincoln Counties who have needs that impact their health-care needs.

A. Target Group (Cont.)

15. Covered services will be provided to children and young adults ages 5 to 21 who are enrolled in a school administrative district or a private school approved for the provision of special education and supportive services in Maine who are exhibiting high risk behaviors that may result in social, emotional or academic failure.

16. Covered services will be provided to a family or child if the child is under the age of 18 years and participating in the Healthy Families Program.

17. Covered services will be provided to recipients diagnosed with diabetes mellitus and/or asthma including education of a parents or guardians with regard to care of the recipient.

E. Qualification of Providers: (cont.)

1. Mentally Ill Adults

Case management services will be provided by individual support coordinators, regional supervisors in the regional office of the Department of Behavioral and Developmental Services. Individual support coordinators and case managers must have a BA degree and three years experience in mental retardation or a related field; regional supervisors must have a BA degree and a minimum of four year's experience in the mental retardation field.

2. HIV

Case management services will be provided by approved staff of agencies designated and approved by the Community Services Center. Approved staff include:

Social Worker

A social worker must hold a valid license from the state or province where services are provided.

Registered Nurse

A registered nurse must have a current and valid license as a registered nurse from the state or province where services are provided and must also have appropriate professional experience in case management, as determined by the case management agency and the Community Services Center.

Other Qualified Staff

Other qualified staff must have a Bachelor's Degree or comparable experience, at least two years of casework experience, and at least one year of experience in providing services to persons with HIV infection.

3. Birth–5

Case Management services will be provided by the following individuals:

A. Local Coordination Site Case Coordinator

An LCS Case Coordinator shall hold a baccalaureate degree in early childhood, special education or related field of study from an accredited institution, or shall have equivalent experiences in the field and perform such duties under the supervision of the manager of the LCS.

B. Public Health Nurse

A Public Health Nurse is a staff level professional of the Bureau of Health who is licensed as a Registered Professional Nurse from the Maine State Board of Nursing, and who works in an assigned area with responsibilities that include visiting home and field sites to encourage adequate medical care and treatment, conducting clinics and conferences where nursing services are provided, and advising and assisting individuals and groups on nursing and health needs.

E. Qualifications of Providers: (cont.)

C. When Services Are Provided Throunh A Head Start Anencv

1. Head Start Case Manager

A Head Start Case Manager shall have six college credit hours in early childhood education, special education, social services or a related field or shall have equivalent experience in the field and perform such duties under the supervision of the Head Start Case Management supervisor.

2. Head Start Case Management Supervisor

A Head Start Case Management Supervisor shall have a minimum of a Child Development Associate Certificate, Social Service Competency Based Training Certificate, Associate's degree in early childhood education, special education, social services or a related filed of study with two years experience in a directly related children's service field.

4. Children Abused/Neglected

Case management services will be provided by the following individuals who must be licensed in accordance with Title 32, **M.R.S.A.** Chapter **83,** Sect. 7001-A, with the exception of human services caseworker trainees:

Caseworker

A caseworker must have as a minimum the following education and/or experience: (a) a baccalaureate or master's degree in social work from an accredited school; -OR- (b) a master's of education in counseling and one year of case management experience; -OR- (c) a baccalaureate degree in either psychology, sociology, counseling, human development, child development, social welfare or a related field and one year of case management experience in professional social work; -OR- (d) five years of professional social work case management and fifteen credit hours in areas of counseling, guidance, psychology, sociology, or human/child development if licensed under the social worker licensing grandfathering clause.

Human [illegible] Trai

A human services caseworker trainee must have a baccalaureate degree in psychology, sociology, counseling, human development, child development, social welfare, nursing, education, rehabilitation or a related field, or, four years of professional social work case management, including a minimum of fifteen credit hours in areas of counseling, guidance, psychology, sociology and/or human or child development.

E. Qualification of Providers: (Cont.)

5. Children/Young Adults Care or Custody

Case management services will be provided by the following state employees or contracted staff who must be licensed in accordance with Title 32, M.R.S.A., Chapter 83, Sect. 7001-A, with the exception of human services caseworker trainees:

Human Services Caseworker

A human services caseworker must have as a minimum the following education and/or experience: (a) a baccalaureate or master's degree in social work from an accredited school; -OR- (b) a master's of education in counseling and one year of case management experience; -OR- (c) a baccalaureate degree in either psychology, sociology, counseling, human development, child development, social welfare or a related field and one year of case management experience in professional social work; -OR- (d) five years of professional social work case management and fifteen credit hours in areas of counseling, guidance, psychology, sociology, or human/child development if licensed under the social worker licensing grandfathering clause.

Human Services Caseworker Trainee

A human services caseworker trainee must have a baccalaureate degree in psychology, sociology, counseling, human development, child development, social welfare, nursing, education, rehabilitation or a related field, or, four years of professional social work case management, including a minimum of fifteen credit hours in areas of counseling, guidance, psychology, sociology and/or human or child development.

6. Adult Protective

Case management services will be provided by the following individuals:

Human Services Caseworker Trainee

A human services caseworker trainee must have a baccalaureate degree in psychology, sociology, counseling, human development, child development, social welfare, nursing, education, rehabilitation or a related field or, four years of professional social work case management, including a minimum of fifteen credit hours in areas of counseling, guidance, psychology, sociology and/or human or child development.

Human Services Caseworker.

A human services caseworker must have as a minimum the following education and/or experience: (a) a baccalaureate or master's degree in social work from an accredited school; -OR- (b) a master's of education in counseling and one year of case management experience; -OR- (c) a baccalaureate degree in either psychology, sociology, counseling, human development, child development, social welfare or a related field and one year of case management experiencing professional social work; -OR- (d0 five years of professional social work case management ad fifteen credit hours in areas of counseling, guidance, psychology, sociology, or human/child development. A human services caseworker must be licensed in accordance with 32 M.R.S.A., §7001-A.

Human services Caseworker Suoervisor

A human services casework supervisor must have as a minimum, the following education and/or experience: eight years of education, preferably a MSW degree, and/or professional experience in social work. A casework supervisor is responsible for supervising the caseworkers and ensuring the provision of quality case management services. A human services casework supervisor must be licensed in accordance with 32 M.R.S.A., §7001-A.

7. Through 20 years of Age

Where covered services are provided by staff of the Department of Behavioral and Developmental Services or agencies under contract to provide case management services, services will be provided by the following individuals:

A. 1. Level I Case Manager

A Level I Case Manager may be either a professional position as defined for Level II Case Managers or may be performed by an individual who has parented a child or adolescent with special needs.

2. Level II Case Manager

Level II Case Managers are professional positions. Staff must have a minimum of a Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in counseling, psychology, social work, special education, mental health and human services, behavioral health, behavioral sciences, child development, rehabilitation, sociology, nursing or closely related field, or be a graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, or closely related field, or be a Registered Nurse with at least two years of full-time equivalent psychiatric experience with children or adolescents.

B. Psychiatrist

A psychiatrist must be licensed in a state or province in which services are provided.

C. Psychologist

A psychologist must be licensed in the state or province in which services are provided.

D. Psychiatric Nurse

A psychiatric nurse must: (a) be licensed as a registered professional nurse by the Maine State Board of Nursing, and (b) either (I) hold a master's or higher degree in psychiatric or mental health nursing, awarded from an accredited institution of higher learning or (2) be certified b the American Nurses' Association as a psychiatric and mental health nurse, a clinical specialist in adult psychiatric and mental health nursing or a clinical specialist in child and adolescent psychiatric and mental health nursing.

Qualification of Providers: (Cont.)

E. Other Qualified Mental Health/Developmental Personnel

All other qualified mental health/developmental personnel are staff members of a program licensed, funded, operated or designated by the Department of Behavioral and Developmental Services and who either (1) have a Bachelor's Degree and 3 years experience in special education, child development, mental health or a related field or (2) have the equivalent combination of directly-related training, education and experience in mental health; behavioral or developmental areas, and who are supervised by professional staff and certified by DBDS, as documented by written evidence on file with DBDS.

F. Licensed Clinical Professional Counselor

A licensed clinical professional counselor must be licensed as such by the Maine State Board of Counseling Professionals Licensure in accordance with 32 M.R.S.A., Chapter 119, as documented by written evidence from that Board.

8. Children and Adolescents with Serious Emotional Disturbance Age 11 – 17 Residing in Cumberland County

Case management services shall be provided by:

a. Social Worker licensed by the Maine State Board of Social Work Registration with at least one year of experience in a health or social service field.

b. Social Services Specialist with an Associates Degree (or equivalent) in social services or related field or three years experience with case management in social services or health field.

c. Have the equivalent combination of directly-related training, education and experience in mental health, behavioral or developmental areas, and who are supervised by professional staff and certified, as documented by written evidence on the file with the provider.

9. Juveniles on Probation (Referred or Under the Supervision of Juvenile Caseworkers)

Case management services will be provided by the following individuals:

Probation Officer/Juvenile Caseworker

A probation officer must have as a minimum a baccalaureate degree in social, behavioral, correctional or administrative sciences and six months experience in parole/probation worker, youth/adult counseling, law enforcement activities or equivalent directly related experience/training.

E. Qualification of Providers: (Cont.)

Designated Providers of the Department of Corrections

Individuals must have the following qualifications:

a. a Bachelor's Degree in social, behavioral, correctional or administrative sciences and 1 year's experience working with adolescents or in a related field.

b. the equivalent combination of directly related training, education and experience in mental health, behavioral, developmental areas, or corrections and who are supervised by professional staff and certified by the Department of Corrections, as documented by written evidence on file with the Department of Corrections, or

c. completed a training program to include the topics of juvenile code and corrections, adolescent psychology, suicide, depression, child abuse and neglect protocols, substance abuse, maintaining safety, confidentiality and self-destructive behavior, and are supervised at least weekly by a qualified staff person as defined in (a) above.

10. Pregnant/Postpartum Women and/or Those at Risk of Inadequate Parenting

Case Management will be provided by the following individuals:

a. Reaistered Nurse

A registered nurse must have a current and valid license as a registered nurse by the Maine State Board of Nursing and must also have at least one year of experience in maternal child health and case management.

b. Social Worker

A social worker must be licensed in accordance with 32 M.R.S.A., Section 7001, and must also have at least one year of experience in maternal child health and case management.

c. Other Qualified Staff

Other qualified staff must have a Bachelor's Degree or comparable experience, at least two years of case work experience, and at least one year of experience providing services to pregnant or postpartum women.

11. Adults with Long-Term Care Needs

Case management services for adults with long-term care needs will be provided by case-management staff in the agencies in a contract with the Bureau of Elder and Adult Services and in accordance with the Bureau of Elder and Adult Services' regulations for Home-Based Care.

12. Low income residents of Somerset, Cumberland, Androscoggin, Oxford, Kennebec, Sagadahoc, Waldo, Penobscot, Knox, York and Lincoln Counties who are homeless or at risk of becoming homeless.

E. Qualification of Providers: (cont.)

Case Management staff shall be provided by the following approved staff:

a. Social Worker

A social worker must be licensed by the Maine State Board of Social Work Registration in accordance with 32 M.R.S.A., Chapter 83, and have at least one year of experience in a health or social-service field.

b. Other Qualified Staff

Other qualified staff must have a Bachelor' Degree or at least three years of experience with case management in a health or social-service field.

13. Persons with Psychoactive Substance Dependence

Case management services shall be provided by:

a. Case Managers

Case managers must have a minimum of 4 years education and experience in the social service area.

b. Case Manager Supervisors

Such staff must be licensed by the State of Maine as a Licensed Substance Abuse Counselor, Licensed Clinical Social Worker or a licensed Clinical Professional Counselor.

14. Eligible recipients living in Kennebec, Somerset, Franklin, Oxford, Androscoggin, Sagadahoc, Waldo, Penobscot, Knox, York and Lincoln Counties who have needs that impact their health-care needs.

Case management services may be provided by the following approved individuals:

a. Social Worker

A social worker must be licensed by the Maine State Board of Social Work Registration in accordance with 32 M.R.S.A., Chapter 83, Section 7001, and have at least one year of experience in a health or social service field.

b. Other Qualified Staff/Information and Referral Specialist

Such other qualified staff shall have a Associate's Degree or at least three years of experience with case management in a health or socials service field.

15. Students exhibiting high risk behaviors that may result in social, emotional or academic failure.

E. Qualification of Providers: (cont.)

Case Management services will be provided by designated staff at the local school administrative unit or at the private school approved for the provision of special education and support services. All designated staff must have a bachelor's degree and be duly certified by the Department of Education or licensed in their specialty area and operating within the accepted scope of practice.

16. Healthy Families Program

Case Management services will be provided by staff of the health family providers, who have completed a Healthy Families Core Training and are approved by the Bureau of Health.

17. Case Management Services for individuals with Asthma and Diabetes

A. Diabetes Case Management:

Case management services will be provided by staff of certified as ambulatory diabetes education and follow-up providers and enrolled by the Maine Diabetes Control Program.

B. Asthma Case Management:

Case management services will be provided by a licensed health professional or a health educator with a baccalaureate degree.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entitles under other program authorities for this same purpose.

State/Territory: Maine

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

C. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

D.O. Code _____

THIRD PARTY RESOURCE INFORMATION REQUEST

[ ] NewApp [ ] Review [ ] Change/Cancellation [ ] TANF [ ] Medicaid

Case Name: _____ Case ID# _____ Tel.# _____

Household Members	Medicaid ID#	DOB	Sex

1. Are you or anyone in the household covered by any health insurance other than Medicare or Medicaid? Yes ___ No ___

**********IF YES, THE FOLLOWING MUST BE COMPLETED**********
PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

2. Name of Policyholder/Employee: _____ SS# _____

Employer's name: _____ Tel# _____
Address _____

Name of insurance company(s) _____
Address _____
_____ Tel# _____

Date policy began: _____ Date ended: _____

Group # _____ Certificate/Policy # _____

Name and address of prescription card company, if any _____
_____ Group# _____ Policy# _____

Name and address of dental insurance company, if any _____
_____ Group# _____ Policy# _____

Name and address of vision insurance company, if any _____
_____ Croup# _____ Policy# _____

3. Is insurance listed above provided by an absent parent? Yes____ No____

If yes, absent parent name _____ SS# _____
Address _____
_____ Tel # _____

ACCIDENT INFORMATION (if applicable)

Name of injured person: _____

Date of accident: _____ Nature of injury _____

Attorney/insurance company name: _____
_____

RIGHTS AND RESPONSIBILITIES ON REVERSE SIDE

Signature _____ Date _____

Benefit Overview
Maine State Employee Health Insurance Program
HMO Choice Point of Service Plan
Effective April 1, 2001

	HMO Choice – Point of Service Coverage	
	Primary Care Physician Level of Benefits	Self-referred Level of Benefits
Important Information	Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service. Coverage described in this column applies when covered services are provided or authorized by your Primary Care Physician, unless otherwise stated. You are responsible for any copayments and coinsurance that apply.	Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service. Coverage described in this column applies when you self-refer to providers or professionals. (The Primary Care Physician does NOT provide or authorize services.) You may be responsible for filing claims and paying balance bills in addition to the deductible, copayments, and coinsurance. You moy also need to pay the provider or professional up front.
Inpatient Admission Review	Scheduled inpatient admissions require preadmission authorization by the Primary Care Physician. For emergency and maternity admissions, you should call your Primary Care Physician within 48 hours after admission.	For scheduled inpatient admissions, you or someone you designate must call 1-800-392-1016 for preadmission review. If you self-refer and do NOT call for review before admission, benefits can be reduced by up to $500. For emergency and maternity admissions, you or someone you designate should call within 48 hours after admission.
Calendar Year Deductible	None	$200 per member $400 per family
Calendar Year Out-of-pocket Limit **(Deductible + Coinsurance. Copayments do not count toward meeting the out-of-pocket limit. Coinsurance paid under the PCP level of benefits counts toward your out-of-pocket *limit* under the self-referred benefit level. Deductibles and coinsurance paid under the self-referred benefit level *do* not *count* toward your out-of-pocket limit under the PCP level of benefits.)**	$500 per member $1,000 per family	$2,000 per member $4,000 per family
Lifetime Maximum Benefits	None	$1,000,000

	HMO Choice – Point of Service Coverage	
	Primary Care Physician Level of Benefits	**Self-referred Level of Benefits**
moking Cessation **Smoking Cessation Program** ***Up to $35 per program, $70 per lifetime***	**100%**	75% after deductible
Medications Prescribed by a Physician ***Up to $200 per calendar year, $400 per lifetime***	Prescription **drug** copayment applies	Prescription drug copayment applies
Physician Follow-up Visits/Counseling ***Up to two per calendar year***	100% after **a** $10 copayment	75% after deductible
)urable Medical Equipment	**100%**	75% after deductible ***Up to $3,000 per member per calendar year***
'rosthetics	**100%**	75% after deductible

es my health plan require e-approval from Green Spring?

Yes. To make sure that you receive the highest level of benefits, call Green Spring before you seek care. When you call, a specially trained mental health professional will approve an initial referral to a network provider. If you don't get this "pre-certification" from Green Spring, your benefits may be reduced or denied. So it makes sense to always call Green Spring ***before*** you receive any mental health care or substance abuse treatment.

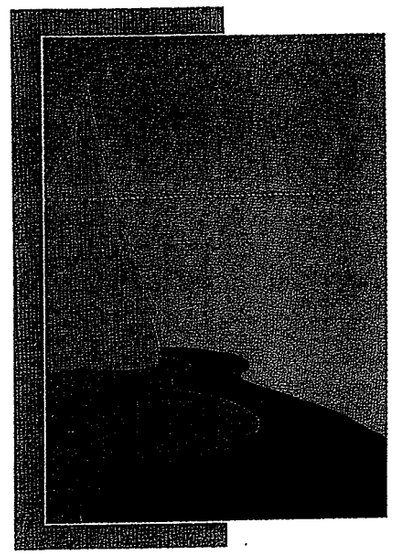
hat should I do in an emergency?

You may feel that emergency care is needed for an emergency that places your mental health or physical health in serious danger, such as an attempted suicide or drug overdose. ***In an emergency, get care right away.*** You should contact Green Spring within 48 hours.

w is my confidentiality protected?

Green Spring treats all records and services with the strictest confidence. The personal information that you share is completely confidential and will only be disclosed as permitted or required by law. All Green Spring employees sign a written commitment to confidentiality, and only employees whose specific jobs require them to carry out an assigned business task access any information. Green Spring's written agreements with providers also require them to maintain your privacy.

GREEN SPRING
HEALTH SERVICES
1-800-755-0851



This brochure provides general information about using your mental health and substance abuse benefits. It is not a contract. Your certificate of coverage, which includes your summary of benefits and any amendments, is your contract. These documents together fully describe the benefits and exclusions. In the event of a conflict between this brochure and your contract, the terms of your contract will govern.

BlueCross BlueShield of Maine
Good for you

An independent licensee of the Blue Cross and Blue Shield Association

043217

GREEN SPRING
HEALTH SERVICES

Your key to mental health and substance abuse services

Everyone needs help from time to time dealing with life's challenges. Friends and family can often support us through difficult times. But where do you turn when you need extra help—when you need mental health or substance abuse services? That's when you call Green Spring Health Services. Your health plan includes a full range of mental health care and substance abuse services. Just call Green Spring, and you're on your way to getting the help you need.

Attachment D

Private Health Insurance Coverage Options

1) As a result of the Omnibus Budget Reconciliation Act of 1990, Maine presently administers a Private Health Insurance Premium Program (PHIPP) that pays insurance premiums for MaineCare members who meet certain criteria based upon guidelines established by the Centers for Medicare and Medicaid Services (CMS). The Bureau of Medical Services Third Party Liability Unit determines if it is cost effective for MaineCare to pay a members premiums for private insurance.

2) Members are told to contact the PHIPP unit if there are any changes in their private insurance plan or if their employer offers any new plans. MaineCare continues to pay for premiums only as long as it is considered cost effective to do so.

3) MaineCare will pay for any level of insurance available to the extent it is cost effective and will then provide MaineCare benefits as a wraparound service to ensure that all individuals on the waiver are eligible to receive the full MaineCare package of benefits.

Attachment E

Cost Sharing

Nominal MaineCare copayments will be required. These are the same copayments paid by the non-expansion MaineCare population. Attached is a copayment booklet that is provided to MaineCare enrollees. Please note this booklet is currently being revised.

What if I can't pay?

If you can't pay, your provider must give you the service anyway. But you may still owe the money to your provider

If you have one of the problems listed below, call 287-2674. Tell them which problem you have.

1. You were charged money when you should not have been;
2. you have already paid up to the limit for the day or the month, but you were asked to pay more;
3. you were charged the wrong amount; and or
4. your provider would not give you the service.

Medicaid Copayments

Are you on Medicaid?

You should know this:

Sometimes you don't have to pay for care, sometimes you do.

If you have to pay, it's called a

copayment

For each service listed below, $1 covers tha service for the day:

laboratory
x-ray

For each service listed below, $2 covers that service for the day:

chiropractor
mental health clinic
occupational therapy
physical therapy
optician
podiatry
substance abuse services
speech therapy
psychology

For each service listed below, $3 covers that service for the day:

ambulance
home health
outpatient hospital
optometry
inpatient hospital
medical equipment
personal care and
private duty nursing

A copayment is charged for each drug you receive.

$2 covers each generic drug
$3 covers each brand-name drug

This is the most you can be charged each month:

$30 a month for each of these services:

ambulance
home health
optometry
outpatient hospital
medical equipment
inpatient hospital

$20 a month for each of these services:

chiropractor
occupational therapy
physical therapy
podiatry
speech therapy
psychologist
mental health clinic
substance abuse services
optical

$5 a month for:

private duty nursing and
personal care services

$10 a month for each of these services:

laboratory
x-rays

The following services are free to everyone on Medicaid:

Oxygen and oxygen equipment

Family planning services

Birth control

Emergency services (emergency means that if you do not get help right away it could:

- place your health in serious danger;
- *cause serious damage to how your body functions; and/or
- *cause serious damage to an organ or part of your body.

If you do not have a "NO" on your card, sometimes you do have to pay.

How much will I have to pay?

How much you pay for care depends on how much the State will pay. You can be charged anywhere from $.50 to $3 a day for these services:

ambulance	laboratory
home health	x-ray
chiropractor	inpatient hospital
occupational therapy	optical
podiatry	optometrist
speech therapy	substance abuse
outpatient hospital	mental health clinic
medical equipment	psychologist
physical therapy	private duty nursing and personal care

You can also be charged anywhere from $.50 to $3 for each drug you receive.

If the State pays less than $10 for a service, you pay $.50.

If the State pays $10 to $25 for a service, you pay $1.

If the State pays $25 to $50 for a service, you pay $2.

If the State pays $50 or more, you pay $2 for everything listed above, except brand-name drugs, home health, ambulance, outpatient hospital, medical equipment, and private duty nursing and personal care. For these you pay $3.

You don't have to pay if you are:

under age 21

in a nursing home

in a boarding home

in a foster home

in a medical institution where you are required to spend part of your income for your care in order to get services there

pregnant, or up to 3 months after your pregnancy ends

in a Health Maintenance Organization (HMO)

in State custody

You should have a "NO" on your Medicaid card if you do not have to pay for part of the cost of your services.

Fair Hearings

If you do not have a "NO" on your Medicaid card and think you should, you can get a fair hearing. To get a fair hearing, write to:

Director
Bureau of Medical Services
DHS
Station 11
Augusta, ME 04333

If you want to, you can bring a lawyer, relative, friend, or other person with you to the hearing. They can help you answer questions.

Attachment F

1) Current population survey adjustment methodology

To calculate the uninsurance rate for persons under 200 percent of poverty in Maine based on The Current Population Survey, data across three years, 1998, **1999,** and 2000, were averaged, to reduce the margin of error. These estimates are for the total Maine Population, including persons over age 65.

2) Effect on uninsurance rate

The Current Population Survey person-level weights were used to estimate population rates. **As** a result of Maine's relatively small population, estimates for specific types of payor coverage have a wider margin of error than would otherwise be expected. To counter **this,** the current actual number of people on MaineCare (formerly Medicaid and SCHIP) in Maine were substituted for the **CPS** estimates. **This** skews percentage coverage rates but provides a more accurate depiction of MaineCare's role in the State. Maine collects information on every enrollee regarding access to private insurance. (See attached form.) **This** information will be analyzed **for** the waiver population.

3) Qualityplan

The vast majority of this expansion population will be enrolled in MaineCare's managed care plan (Primecare). This is a primary care case management plan.

The draft quality monitoring plan for this managed care plan is attached.

D.O. Code _____

THIRD PARTY RESOURCE INFORMATION REQUEST

[ ] NewApp [ ] Review [ ] Change/Cancellation [ ] TANF [ ] Medicaid

Case Name: _____ Case ID# _____ Tel.# _____

Household Members	Medicaid ID#	DOB	Sex

1. Are you or anyone in the household covered by any health insurance other than Medicare or Medicaid? Yes ___ No ___

**********IF YES, THE FOLLOWING MUST BE COMPLETED**********

PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

2. Name of Policyholder/Employee: _____ SS# _____

Employer's name: _____ Tel# _____

Address _____

Name of insurance company(s) _____

Address _____

_____ Tel# _____

Date policy began: _____ Date ended: _____

Group # _____ Certificate/Policy # _____

Name and address of prescription card company, if any _____

_____ Group# _____ Policy# _____

Name and address of dental insurance company, if any _____

_____ Group# _____ Policy# _____

Name and address of vision insurance company, if any _____

_____ Group# _____ Policy# _____

3. Is insurance listed above provided by an absent parent? Yes____ No____

If yes, absent parent name _____ SS# _____

Address _____

_____ Tel # _____

ACCIDENT INFORMATION (if applicable)

Name of injured person: _____

Date of accident: _____ Nature of injury _____

Attorney/insurance company name: _____

_____

RIGHTS AND RESPONSIBILITIES ON REVERSE SIDE

DRAFT
QUALITY IMPROVEMENT PROGRAM
PRIMECARE
STATE OF MAINE

I. INTRODUCTION

Quality management is the integrative process that links knowledge, structure, and processes together throughout a health care organization to assess and improve quality. Quality improvement processes are those activities that the organization undertakes to improve the quality of clinical care and service provided to members. Primecare is a primary care case management organization providing care to Maine Medicaid managed care recipients through a network of independent providers, Primecare is committed to providing high quality health care to its members, and to that end has a comprehensive Quality Management Program.

XI. QUALITY MANAGEMENT PROGRAM

PROGRAM DESCRIPTION AND WORKPLAN

Primecare has a written QI program description which defines the scope and content of the program, as well as the roles and responsibilities of individuals who are involved in the program. It also explains how the program will be evaluated. It describes the role, structure, and function of the QI committee and associated committees. The description contains the goals, objectives, and structure of the QI program. The program description covers Primecare's efforts to monitor and improve clinical and non-clinical aspects of care (e.g., availability, accessibility, coordination). The annual review and revision of the QI program help the staff and QI committee make changes to the program consciously, knowledgeably, and deliberately.

Primecare has a written QI Work Plan which defines the QI program's short-term goals, describes the specific activities that the QI committees and staff involved in the QI activities will undertake to meet these goals, and establishes the time frame for meeting the goals. The Work Plan also provides a structure for measuring progress toward achieving those goals.

QUALITY MANAGEMENT AND IMPROVEMENT STUDIES

PrimeCare undertakes QI studies relevant to its membership. A comprehensive quality improvement program monitors performance and seeks opportunities for improvement across the whole range of health care services that the organization provides. Furthermore, the quality improvement program addresses issues that are likely to have an impact on the organization's membership. To ensure an adequate scope, Primecare assesses the demographics and health risks of its enrolled population and chooses meaningful clinical issues that reflect the health needs of significant groups within that population.

Primecare is responsible for ensuring that the conditions chosen for the assessment address its member population. Clinical quality improvement can be accomplished in several ways, depending on the clinical issue identified for improvement. Regardless of the specific type of quality improvement activity that the organization uses to address its priority clinical issues, the organization undertakes the following steps:

- Identification of priority areas in which the organization wishes to improve the processes or outcomes of health care delivery;
- Identification of the affected population within the enrolled membership;
- Identification of assessment measures by which the organization evaluates its performance;
- Establishment of performance goals, which may be benchmarks (industry best performance), desired level of improvement over current performance, or performance levels that mirror those set by other organizations;
- Collection of valid data for each assessment measure and calculation of the level of performance; and
- Analysis of performance to determine whether performance is appropriate and, if not, to identify the current barriers *to* improving performance.

INTERVENTION AND FOLLOW-UP FOR CLINICAL AND SERVICE ISSUES

Quality improvement requires that Primecare identify opportunities for improvement and take action to improve performance. The organization must continue to measure performance to determine whether improvement is occurring. In some situations, the organization may choose to monitor subsequent performance continuously. In other situations, the organization may monitor subsequent performance only until a specific level of performance is attained.

DATA COLLECTION SYSTEM

The Primecare QI program has adequate resources to meet its short- and long-term objectives and goals. These resources include staff, data collection and analysis resources, space, and equipment. Resources may be dedicated to the QI program or shared with other organizational units.

Primecare has access to data and the ability to manage the necessary data to support the measurement aspects of QI activities in the Work Plan. Specific related areas are the availability and adequacy of data and information system resources for QI, including such sources as claims, encounter data, enrollment data, medical records, and complaints and grievances.

ANNUAL EVALUATION OF EFFECTIVENESS OF QI PROGRAM

Primecare conducts an annual evaluation of the effectiveness of the quality improvement program which allows the organization to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to its membership. Where the evaluation shows that the program has met its goals, the

organization recommends appropriate changes to be incorporated into the subsequent annual quality improvement plan.

An effective QI program demonstrates that its activities have resulted in meaningful improvements in the clinical care and service delivered to its members. This includes activities undertaken to improve the delivery or outcomes of clinical care, to increase the use of preventive'health services, to improve accessibility of all services, and to increase member satisfaction.

Demonstrated improvement is based on the analysis of data from a sufficiently large population (or sample) collected over a sufficiently long period to demonstrate that change is progressive and related to the quality improvement program's interventions. Often, one year is not enough fur a program to show a measurable effect.

The annual QI program evaluation parallels the **Work** Plan for the year. It briefly describes the completed and ongoing QI activities for that year, including any delegated functions.

QUALITY IMPROVEMENT COMMITTEE

PrimeCare has a QI committee [IQC] which is charged with developing, implementing, and overseeing the QI program. To accomplish this, the Committee determines which quality improvement activities Primecare will undertake, analyzes the results of the quality improvement activities to determine if there are opportunities for improvement, approves action plans to effect improvement, and follows up to ensure that the action plans are effective, Associated committees and subcommittees may also participate in these activities. Timely written minutes record committee decisions and actions for internal and external use.

The quality management and improvement program is broad in scope, reflecting the range of clinical care and service issues that are relevant to its enrolled population. Therefore, it is important that the program be directed by a QI committee made **up** of individuals who bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program. This includes clinical practitioners and other staff who are involved in the **provision** of care and service to members. Membership also includes appropriate Primecare administrative and medical personnel, including the Medical Director, and other personnel reflective of the scope of the Primecare program.

SUPERVISION AND RESOURCES

Adequate authority is present for the QI program to function effectively.

Adequate resources are made available to the QI program by Primecare, including both those resources that are regularly devoted to specified QI activities as well as other Primecare **staff** allocated to support the QI program. This includes staffing (employees and consultant staff), data sources, and analytic resources such as statistical expertise and programs.

PROVIDER PARTICIPATION IN THE QI PROGRAM

participating providers as well as access to their medical records to collect data for monitoring and evaluation.

Participating practitioners who are directly involved in the provision of health care and bring a significant "real world" perspective to quality management and improvement activities are involved in the development and implementation of specific quality improvement activities. Participating practitioners who are involved in Primecare's quality improvement program also serve as a communications conduit to the practitioner community. These practitioners help the organization educate its participating practitioners and providers about the principles of quality management and quality improvement, the organization's quality improvement program and its specific quality activities, and the results of these activities. They also solicit feedback from the practitioner and provider community about the program.

111. CREDENTIALING AND RECREDENTLALING

Primecare has a provider credentialing/recredentialing process to ensure availability of providers who will render ongoing, high quality medical services to members. The process also considers all appropriate data of each practitioner prior to their credentialing or recredentialing. The credentialing process helps to ensure that Primecare providers have the requisite medical skills and training, and the appropriate health and moral fitness, to provide care to Primecare members.

Well-defined policies and procedures specify the requirements and the process used to evaluate practitioners, as well as responsible parties. The policies explicitly define the physicians and other licensed independent practitioners who are subject to these policies, as well as the criteria required to reach a decision. The criteria are designed to assess a practitioner's ability to deliver care. They include licensure, relevant training or experience, and disclosure of any health issue that may affect care delivered within the care setting. The policies define the appropriate documentation to verify each criterion. Verification of this information from primary sources is essential to ensure that decisions are based on the most accurate, current information available. At recredentialing, Primecare uses data derived fiom practice experience within the organization as part of its evaluation regarding practitioner retention. Such data include quality improvement findings, utilization data, and member siltisfaction measures.

Written policies/procedures, approved by the [Governing Body] or its formal designee, at a minimum address for all physicians or otherwise licensed dependent or independent practitioners who fall under its scope of authority and action:

(I) Criteria for initial credentialing;

(2) Criteria for credentialing at reappointment;

(3) Definition of periodicity of reappointment;

(4) Process for development of a provider profile including ongoing accumulation of all quality improvement activities/utilization data/performance measures/member complaints or compliments/satisfaction surveys for consideration in the reappointment process;

(5) Process for consideration of corrective/remedial actions for non-compliant providers in the reappointment process, incorporating:

- → quality of care standards
- → clinical practice guidelines
- → utilization standards
- → medical records documentation standards
- → ethics/citizenship standards
- → cooperation with plan goals and objectives
- → provider access
- → member complaints
- → member satisfaction surveys

(6) Documentation of conditions under which privileges or Primecare affiliation would/could be suspended/terminated/reduced;

(7) Mechanism for reporting of serious quality or performance deficiencies which result in change in privileges to the appropriate authorities;

(8) Provider credentialing process.

CREDENTIALING COMMITTEE

Primecare designates a credentialing committee or other peer review body that makes recommendations regarding credentialing/recredentialing decisions and is accountable to the (Governing Body].

Meaningful advice from participating practitioners in the credentialing processes adds validity to the system by including technical knowledge that may not otherwise be available to Primecare. Such advice also helps ensure that procedures are followed consistently. Practitioners bring expertise on current practices in the medical community and provide advice on modifying the criteria, as appropriate. This expertise may be obtained **from** a committee with participating practitioner representation.

CREDENTIALING APPLICATION

A completed application form with the requested supporting documentation initiates the credentialing process. Credentialing decisions are not based on the application alone, but it is an important element in the process. Through the application form, the practitioner discloses information about health status and any history of issues with licensure or privileges that may require additional follow-up. Primecare uses the information supplied to determine whether further corroboration or investigation is needed. The signed attestation statement on the application asserts that the practitioner has completed it in good faith.

The credentialing application includes a statement by the applicant regarding:

1. **Any** physical or mental health problems that may affect ability to provide health care;
2. **Any** history of chemical dependency/substance abuse;
3. History of loss of license and/or felony convictions;
4. History of loss or limitation of privileges or disciplinary activity;
5. The applicant attests to correctness/completeness of the application.

PRIMARY SOURCE VERIFICATION

Primecare has a timely credentialing process to assure members that it uniformly identifies practitioners who have the requisite training and experience to provide care. Evaluating practitioners in a timely fashion facilitates early detection of potential problems that may have an impact on the care provided to members.

The credentialing policies and procedures specify the professional criteria that Primecare requires for participation. Criteria in **the** standard were chosen for verification because they identify the legal authority to practice **as** well as the relevant training and experience required. They confirm that Primecare addresses issues that **may** affect the care provided to the members.

Each practitioner's file contains sufficient documentation to demonstrate that these criteria are evaluated. Primecare verifies the information through a primary source to ensure that decisions are based on accurate, current information. Primecare may **use an** external agency (e.g., a county medical society, hospital association, or private verification service) to collect information from the primary sources. Primecare approves the primary sources that the external agency uses and audits the information.

RECREDENTIALING

As part of the formal recredentialing Process, Primecare reverifies the credentialing information that is subject to change over time. Static historical elements such as medical education and residency do not need to be reverified. The intent of the process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the practitioner's ability to perform the services that he or she is under contract to provide.

PrimeCare records in each practitioner's file that compliance with these criteria is current at the time of recredentialing. Primecare verifies the information through a primary source to ensure that decisions are based on accurate, current information. Primecare may delegate this data collection to an external agency (e.g., a county medical society, hospital association, or other verification service).

IV. EVALUATION OF PRACTITIONER SITE AND MEDICAL RECORDS

Primecare practitioners provide care and service from multiple locations and offices, which are generally not owned or operated directly by the organization. Most patient care is provided in practitioners' offices rather than institutions such as hospitals. For this reason, the credentialing process includes a structured review of the quality of the facility within which the care is provided. This review of the facility helps to assure the member and PrimeCare of the physical accessibility of the space and the adequacy of the examination and waiting areas at each office site. Primecare assesses the adequacy of medical record keeping practices to ensure that all relevant medical information is documented, and is available for other providers of care.

The structured site visit review process includes:

- a standard site visit review form that is completed at the time of, or shortly after, each site visit. The review 'evaluates the site against Primecare's organizational standards
- a set of criteria for the office review that is incorporated into the site visit form and includes an assessment of the following:
  - physical accessibility
  - physical appearance
  - adequacy of waiting and examining room space
  - availability of appointments
  - conformance of medica1 record keeping practices with Primecare's standards.

V. ENROLLMENT CRITERIA

Primecare ensures that members are allowed to change enrollment for cause at any time, and without cause within 90 days of notification of enrollment, and without cause at least every 12 months thereafter.

COMPLAINT AND GRIEVANCE PROCEDURES

ys of making its
i) provides such

1 and consistent procedures for responding to complaints and grievances. The procedures
valuation of complaints from both sides. If the complaint involves clinical issues, such as
ss to care, or appropriateness of care, the evaluation includes a review of the clinical
the case. Furthermore, the organization's procedures are designed to recognize that a
a problem that PrimeCare needs to address across its system.

es that disputes may arise with its members, particularly over the coverage of services, ent for, the
mplaints. The organization is prepared to resolve these disputes. The policies for
ly a defense of the organization's own decisions but rather constitute a process of epartment; and
's appeal from both sides. When a member appeals a decision, Primecare conducts a new espects.

ds for timeliness in resolving complaints and grievances which recognize the urgency of
ember. This means that Primecare handles cases on an emergency basis when necessary.

ocumentation of its handling and monitoring of cornplaints and grievances in order to th members that
en and the compliance with standards for timeliness.

iprovement.
neasures to

n or oral statement by a member expressing dissatisfaction with some aspect of the
resolution of the situation. A grievance is a formal action undertaken when the
resolved to the member's satisfaction and the member requests reconsideration of the

ped a fair and impartial dispute resolution procedure. The system, and any revisions to the
he Department, includes the following:

ite and chronic
nbers initially
sufficient
milarly,

fying enrollees how to file a complaint, grievance or request for a Department fair hearing,
ess to a toll free telephone line, the title of the person who is responsible for responding to
laints or grievances at each step of the process, and the enrollee's right to grieve directly to
nt at any time;

e and number
a member of

nd grievance system with specified time frame for resolution and a record keeping system
s and grievances and their disposition; and

as primary care

view and analyze, annually, complaints and grievances and the disposition of such
d grievances and identify and implement opportunities for improvement.

establishes
ne availability of
itioner
intervention
ine whether the

written notice to an enrollee of the enrollee's rights whenever it denies, reduces, terminates
ce an enrollee has requested. Approved revisions to Primecare's complaint and grievance
mmunicated, in writing, to Primecare's enrollees at least ten (10) business days prior to

ent with a
eCare, usually

members are able to obtain information about how to access clinical care, to resolve problems they experience, and to make appointments.

In monitoring the accessibility of care and telephone service, Primecare establishes standards for appointment availability, after-hours access, and access to telephone service; collects data and assesses performance against the standards; identifies and prioritizes opportunities for improvement; implements intervention strategies to improve performance, as indicated; and remeasures to determine the extent to which accessibility has improved.

IX. MEDICAL RECORDS STANDARDS

The medical record, whether electronic or on paper, communicates the patient's past medical treatment, past and current health status, and treatment plans for future health care. Primecare demonstrates organizational accountability through the establishment and promulgation of medical records standards including timeliness and legibility. Well-documented medical records, whether electronic or on paper, facilitate communication, coordination, and continuity of care and promote the efficiency and effectiveness of treatment.

Primecare includes provisions in its contracts with providers for appropriate access to the medical records of Primecare members for purposes of quality reviews to be conducted by **HCFA,** the State or its delegate and independent review entities, and for the medica1 records to be available to health care practitioners for each clinical encounter. Primecare ensures that a primary medical record is maintained for each member which contains sufficient medical information from all providers involved in the care to insure continuity of care. PrimeCare will ensure that all providers involved **in** the care know how to access the member's medical records.

Primecare has information and record transfer procedures to provide continuity **of** care when members are treated **by** more than one provider or outside the Primecare network. Primecare has medical record/confidentiality policies and procedures and a process to inform providers of its policies.

Primecare **has** medical records documentation standards which are enforced and which require that the records reflect all aspects of patient care, including ancillary services. These standards include the following:

- patient identification information (name or ID number);
- entry date;
- provider identification (author of entry);
- immunizations;
- allergies;
- past medical history;
- diagnostic information;
- medication infomation;
- history of smoking and alcohol use and substance abuse;
- consultations, referrals and specialist reports;
- reports of emergency care;
- hospital discharge summaries;
- advance directives;

3 patient visit data including subjective and objective information for the presenting complaints; diagnoses and differential diagnoses; plan of treatment; diagnostic tests and/or result thereof; drugs prescribed, including the strength, amount, directions for use for initial and refills; therapies and other prescribed regimens and/or results thereof; follow-up plans and/or directions (time for return visit, symptoms which should prompt a return visit, etc.).

X. DOCUMENTATION OF QI ACTMTIES

As part of Primecare's obligation to perform QI activities to improve the health of its membership, Primecare agrees to make available to the State or its delegate, HCFA or independent review entities, studies, reports, protocols, standards, worksheets, minutes or other such documentation as may be appropriate, concerning its quality improvement activities and corrective actions.

XI. QI COORDINATING WORKGROUP

The Department has established an ongoing QI Coordinating Workgroup to foster mutual cooperation in optimizing efficiency in the QI activities and to promote cross-linkages in identified areas of concern. Members of this workgroup include, at a minimum, Primecare medical director(s), the medical director for the Medicaid Program, and the contract managers.

D.O. Code _____

THIRD PARTY RESOURCE INFORMATION REQUEST

[ ] New App [ ] Review [ ] Change/Cancellation [ ] TAM: [ ] Medicaid

Case Name: _____ Case ID# _____ Tel.# _____

Household Members	Medicaid ID#	DOB	Sex

1. Are you or anyone in the household covered by any health insurance other than Medicare or Medicaid? Yes ___ No ___

**********IF YES, THE FOLLOWING MUST BE COMPLETED**********
PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

2. Name of Policyholder/Employee: _____ SS# _____

Employer's name: _____ Tel# _____
Address _____

Name of insurance company(s) _____
Address _____
_____ Tel# _____

Date policy began: _____ Date ended: _____

Group # _____ Certificate/Policy # _____

Name and address of prescription card company, if any _____
_____ Croup# _____ Policy# _____

Name and address of dental insurance company, if any _____
_____ Croup# _____ Policy# _____

Name and address of vision insurance company, if any _____
_____ Croup# _____ Policy# _____

3. Is insurance listed above provided by an absent parent? Yes _____ No _____

If yes, absent parent name _____ SS# _____
Address _____
_____ Tel # _____

ACCIDENT INFORMATION (if applicable)

Name of injured person: _____

Date of accident: _____ Nature of injury _____

Attorney/insurance company name: _____
_____

RIGHTS AND RESPONSIBILITIES ON REVERSE SIDE

Signature _____ Date _____

Attachment *G*

Budget Worksheets

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MANDATORY POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
>65								
Eligible Member Months	0.00%	0	-	-	-	-	-	
Total Cost per Eligible	0.00%	0	-	-	-	-	-	
Total Expenditure			0	0	0	0	0	0
Pop. 2								
Eligible Member Months	0.00%	0	-	-	-	-	-	
Total Cost per Eligible	0.00%	0	-	-	-	-	-	
Total Expenditure			0	0	0	0	0	0
Pop. 3								
Eligible Member Months	0.00%	0	-	-	-	-	-	
Total Cost per Eligible	0.00%	0	-	-	-	-	-	
Total Expenditure			0	0	0	0	0	0

EXISTING OPTIONAL POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	PERCENT REDUCED	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Pop. 1									
Eligible Member Months	0.00%	0		-	-	-	-	-	
Total Cost per Eligible	0.00%	0	0	-	-	-	-	-	
Total Expenditure				0	0	0	0	0	0
Pop. 2									
Eligible Member Months	0.00%	0		-	-	-	-	-	
Total Cost per Eligible	0.00%	0	0	-	-	-	-	-	
Total Expenditure				0	0	0	0	0	0
Pop. 3									
Eligible Member Months	0.00%	0		-	-	-	-	-	
Total Cost per Eligible	0.00%	0	0	-	-	-	-	-	
Total Expenditure				0	0	0	0	0	0

NEW OPTIONAL POPULATIONS

ELIGIBILITY GROUP	ANTICIPATED FIGURES	TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Eligible Member Months				-	-	-	-	
Total Cost Per Eligible				$ -	$ -	$ -	$ -	
Total Expenditure	$ -		$ -	$ -	$ -	$ -	$ -	$ -
Eligible Member Months				-	-	-	-	
Total Cost Per Eligible				$ -	$ -	$ -	$ -	
Total Expenditure	$ -		$ -	$ -	$ -	$ -	$ -	$ -

EXPANSION POPULATIONS

ELIGIBILITY GROUP	ANTICIPATED FIGURES	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
[redacted]									
Eligible Member Months	[redacted]				154,569	163,735	173,444	183,729	
Total Cost per Eligible	[redacted]		0		$ 274	$ 288	$ 298	$ 311	
Total Expenditure	$ 34,701,476			$ 38,375,908	$ 42,351,806	$ 46,828,210	$ 51,686,312	$ 57,139,719	$ 236,382,055
[redacted]									
Eligible Member Months	[redacted]				-	-	-	-	
Total Cost per Eligible	[redacted]		0		-	-	-	-	
Total Expenditure	0			-	-	-	-	-	-